7750 Montpelier Rd., Laurel, MD 20723 800 735 2968 (FAX) 410 888 9004

Health History Intake

Today's Date ___________________

Name___________________________________ Telephone Day ____________ Night____________
Address____
Email_____________________________________

Emergency Contact Name __________________ Relationship __________ Telephone ____________
Address ____

Regular Physician Name __________________ Date Last Appt _________ Telephone ____________
Reason for Appt ___________________ Address ____

Date of Birth______________ Age____ Place of Birth______________ Ethnicity ________________
Religion ______________ Eye Color_________ Hair Color _________ Height _______Weight _______
Most you have weighed as an adult ____ Year ____
Least you have weighed as an adult ____ Year ____
Where and when have you lived or traveled outside the U.S. or Canada? ____________________
____
Occupation ________________ How long? _____ On a scale of 1 to 10 (high) how stressful? ____
Previous occupation __________________ Education (Highest level attained) _________________
Marital (Union) status _______________ Number of times: Divorced ____ Widowed ____

What concerns would you like to address?

1. ____
2. ____
3. ____

How long have you had these conditions? ____
In order to change these conditions, are you willing to make modifications in your lifestyle? _____

What other health related issues have you had in the past?
Year/Condition ____
Year/Condition ____
Year/Condition ____

Family Relationship	**Alive/Deceased**	**Present health or cause of death**
Father	________	______________________________
Mother	________	______________________________

	# Alive	**Health**	**# Deceased**	**Cause of Death**
Brothers	_______	________________	_________	________________
Sisters	_______	________________	_________	________________
Children/ages	_______	________________	_________	________________
	_______	________________	_________	________________

Check illnesses which have occurred in any of your blood relatives:
__ Diabetes __ Cancer __ Bleeding Tendency __ Kidney Disease __ Tuberculosis __ Allergy
__ Heart Disease __ Stroke __ High Blood Pressure __ Nervous Illness __ Other ____________

List the types of foods you eat for a:

Typical Breakfast ____
Typical Lunch ____
Typical Dinner ____
Snacks & Times eaten ____
What foods do you crave? ____
What food do you react to? ____
Have you had allergies or sensitivity to medicines or other substances? No __ Yes __ List: ______
____

Do you Use:

	Now	In the Past	Type	Amount/Day	For how long?
Tobacco	_____	__________	_____	____________	____________
Alcohol	_____	__________	_____	____________	____________
Coffee	_____	__________	_____	____________	____________
Recreational Drugs	_____	__________	_____	____________	____________

Do you exercise regularly? ________________ List the type of exercise you get in a typical week.
Type of Exercise _______________ How often ________________ How long _______________
Type of Exercise _______________ How often ________________ How long _______________
Type of Exercise _______________ How often ________________ How long _______________

Medications currently or previously used

Name	Dosage/Frequency	Duration

Supplements/vitamins/herbs currently used

Name	Dosage/Frequency	Duration

Please list any major health conditions: ____
____

UPPER GI

____ Sometimes nausea in evenings	____ Sometimes nausea in mornings
____ Mouth frequently too dry	____ Sometimes excess salivation
____ Duodenal ulcer	____ Stomach ulcer
____ Sometimes foul burps	____ Strong, demanding hunger
____ Butterflies in stomach	____ Seldom eat breakfast
____ Often don't finish meals	____ Often eat to calm down
____ Receding gums	____ Frequent use of alcohol
____ Frequent poor appetite	____ Bitter taste in morning
____ "Dragon breath" in morning	____ Acid indigestion at night
____ Frequent mouth cold sores	____ Sometimes difficulty in swallowing
____ Indigestion after eating	

LOWER GI

____ Constipation with gas	____ Stools loose with gas
____ Frequent constipation	____ Digestion unusually rapid
____ Light colored, hard stools	____ Loose stools when tired/stressed
____ Intestines often bloated	____ Dark, soft stools
____ Constipation with hemorrhoids	____ Quick defecation after eating
____ Constipation with painful defecation	____ Constipation w/ fully formed stools
____ Constipation w/ hard, marbly stools	____ Tongue often coated

LIVER

____ Dry, even scaly skin	____ Moist, sometimes oily skin
____ Hay fever or asthma	____ Hives from food or drugs
____ Craves fruit or sweet	____ Craves proteins, fats
____ Frequent trouble digesting fats	____ Fever with sweat when sick
____ Acne on face AND buttocks	____ Seem to have low blood sugar
____ Had hepatitis in past	____ Frequent use of alcohol
____ Work with solvents	____ Psoriasis, eczema, dermatitis
____ Frequent minor illnesses	____ Don't sweat when sick

RENAL

____ Standing too quickly causes faintness/dizziness	____Wakes up at night to urinate
____ Standing too quickly makes pulse roar in ears	____ Frequent water retention
____ Frequent flushing of blushing	____ Urine usually dark
____ Moderate low blood pressure	____ Moderate high blood pressure
____ Frequent thirst	____ Craving for salt
____Urine always light colored	

LOWER URINARY TRACT

____ Frequent urination, small amounts	____ Infrequent urination, copious
____ Sometimes dribble afterwards	____ Frequent bladder infections
____ Demanding need to urinate	____ Mucus in urine
____ Benign prostatic hypertrophy	____ Dull ache after urination

REPRODUCTIVE

____ Dry skin, cold hands and feet
____ Sweat freely with stong scent
____ Oily skin, facial acne

WOMEN

____ Cycle more than 28 days
____ Cycle less than 28 days
____ Miss some periods
____ Water retention before menses
____ Menses slow starting with cramps
____ Menstruation always lengthy
____ Constipation before, loose stools after menses starts
____ Frequent Class II Pap smear
____ Always hungry before menses
____ History of PID, cervicitis
____ Breasts tender before menses
____ Miscarriages, problem pregnancy
____ Palpitations before menses
____ Period late with altitude change
____ Period early with altitude change
____ Tried, but couldn't take birth control pills
____ Hot flushes

MEN

____ Frequent cannabis user
____ Pain or ache after orgasm
____ Difficult maintaining erection when in the mood
____ Benign prostatic hypertrophy

RESPIRATORY

____ Shortness of breath when standing or walking
____ Easy coughing of mucus
____ Tobacco smoker
____ Sometimes hyperventilates
____ Difficulty swallowing mucus
____ Rapid, shallow breather
____ Sometimes wake up choking or gasping for breath
____Yawns frequently
____ Frequent chest colds

CARDIO-VASCULAR

____ Fast, light pulse
____ Slow, strong pulse
____ Cold bodied
____ Frequent physical activity
____ Sometimes dizzy or faint
____ Warm bodied
____ Hands cold, clammy or dry
____ Hands warm, sweaty
____ Hypertension, not responding to diuretics
____ Hypertension responds to diuretics
____ Palpitations either as an adolescent or before menses

LYMPHATIC

____ Recuperates slowly if ill
____ Recuperates quickly if ill
____ Injuries heal slowly
____ Injuries heal quickly
____ Eczema, dermatitis
____ Asthma or hay fever
____ Arthritis or rheumatism

SKIN

____ Skin eruptions are deep, not coming to a head
____ Skin on trunk is dry
____ Skin eruptions are superficial, come to a head
____ Oily scalp or hair
____ Cracks, fissures on heel, elbow, feet, heal poorly
____ Dry scalp or hair

MUCUS

____ Sores, cracks, fissures in mouth, anus, vagina	____ Lips often dry, chapped
____ Food often causes intestinal distress as it passes	____ Gets sore throat easily

GENERAL

Mark all that apply. If mild, mark "1"; if strong, mark "2".

____ Awakens, can't go back to sleep	____ Increase in weight (recent)
____ Bad dreams	____ Lack of sensation somewhere
____ Blurred vision	____ Likes depressants
____ Brown spots, bronzing of skin	____ Likes stimulants
____ Bruises easily	____ Lower back pain
____ Can't gain weight	____ Muscle cramps
____ Can't lose weight	____ Nails split, brittle
____ Can't get started without coffee	____ Nose bleeds frequently
____ Chemical or spray poisoning	____ Pollution heavy in environment
____ Chronic fatigue, depression	____ Ringing in ears
____ Cry easily without apparent cause	____ Pulse speeds up after meals
____ Depressed for long periods	____ Sensitive to cold weather
____ Earaches	____ Sensitive to hot weather
____ Eat often or else faint/nervous	____ Sensitive to high humidity
____ Eyes often red/inflamed	____ Sensitive to low humidity
____ Face, eyes get puffy	____ Sexual desire decreased
____ Facial twitches	____ Sexual desire increased
____ Gum problems	____ Stuffy nose during the day
____ Headaches	____ Stuffy nose in evening/night
____ Headaches in morning, wearing off	____ Tendency to anemia
____ Heart palpitations when hungry	____ Tremors in hands or neck
____ Heart palpitation after eating	____ Varicose veins
____ Highly emotional	____ Highly controlled
____ Weight gain in upper arms, shoulders, back of neck	
____ Impaired hearing	

ADDITIONAL THINGS YOU WANT TO MENTION

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____