



<b>PRIOR HEALTH HISTORY / DIAGNOSES</b>		
<b>Diagnosis</b>		<b>Date</b>
<b>CURRENT/RECENT HEALTHCARE PROVIDERS</b>		
<b>Name</b>	<b>Dates</b>	<b>Care Provided</b>
<b>COMPLEMENTARY OR ALTERNATIVE TREATMENTS</b>		
<b>Type</b>		<b>Dates</b>
<b>ALLERGIES</b>		
<b>Allergen</b>	<b>Reaction</b>	

HOSPITALIZATIONS & SURGERIES			
Date	Hospital	Diagnosis/Operation	Doctor
CHEMOTHERAPY			
Date	Type or Name of Drug	Dosage	Number of Rounds
RADIATION THERAPIES			
Date	Dosage	Number of Courses	
CENTRAL LINE (fill this out if you have a central line)			
Type of Line	Date Installed	Installed at (hospital name)	
SUPPLEMENT LIST			
Name	Dose	Start Date	

## CURRENT MEDICAL STATUS

Please check the ONE that best describes your general health today:

- Normal activity level, no evidence of disease
- Able to carry on normal activity; minor signs or symptoms of disease
- Able to carry on normal activity with effort; some signs or symptoms of disease
- Cares for self; unable to carry on normal activity or do active work
- Requires occasional assistance, but is able to care for most needs
- Requires considerable assistance and frequent medical care
- Disabled; requires special care and assistance

Please tell us about the specifics of your health history. If the following applies to you please indicate how often it happens or how bothersome it is to you:

0 - Never happens, not a problem

1 - Happens sometimes but it doesn't really bother me

2 - Occurs frequently and it bothers me

3 - Occurs often and this is really a problem I need help with

### General

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Afternoon fevers | <input type="checkbox"/> Chronic fatigue  | <input type="checkbox"/> Poor sleep      |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Night sweats     | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> No/low sex drive | <input type="checkbox"/> Under weight    |
|   | <input type="checkbox"/> Over weight      |  |

Other: \_\_\_\_\_

### Allergy & Immune System

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Epstein-Barr     | <input type="checkbox"/> Mononucleosis      |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Frequent "colds" | <input type="checkbox"/> Weak immune system |

Other: \_\_\_\_\_

### Heart and Circulation

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Angina pains           | <input type="checkbox"/> High blood pressure          | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Palpitations or fibrillation | <input type="checkbox"/> Swelling in ankles and/or feet |
| <input type="checkbox"/> Cold hands/feet        | <input type="checkbox"/> Phlebitis                    | <input type="checkbox"/> Tightness in chest             |
| <input type="checkbox"/> Heart attack           | <input type="checkbox"/> Shortness of breath          | <input type="checkbox"/> Varicose veins                 |

Other: \_\_\_\_\_

### Endocrine

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Addison's disease | <input type="checkbox"/> Hormones imbalanced | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Irregular periods   | <input type="checkbox"/> Weak adrenals     |

Other: \_\_\_\_\_

**Head, Eyes, Ears, Nose &**

**Throat**

\_\_\_\_\_ Eye/vision problems

\_\_\_\_\_ False teeth

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Frequent headaches

\_\_\_\_\_ Gum/teeth problems

\_\_\_\_\_ Hearing problems

\_\_\_\_\_ Lots of fillings

\_\_\_\_\_ Root canals

\_\_\_\_\_ Swollen glands

**Digestive System**

\_\_\_\_\_ Appendicitis

\_\_\_\_\_ Colitis

\_\_\_\_\_ Crohn's Disease

\_\_\_\_\_ Diverticulitis

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Frequent gas/flatulence

\_\_\_\_\_ Hemorrhoids

\_\_\_\_\_ Hepatitis

\_\_\_\_\_ Hypoglycemia

\_\_\_\_\_ Jaundice

\_\_\_\_\_ Parasites

\_\_\_\_\_ Stomach ulcer

**Genito-Urinary**

\_\_\_\_\_ BPH (enlarged prostate)

\_\_\_\_\_ Blood in urine

\_\_\_\_\_ Difficult urination

\_\_\_\_\_ Dribbling urine

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Erectile dysfunction

\_\_\_\_\_ Frequent urination

\_\_\_\_\_ Getting up at night to urinate

\_\_\_\_\_ Impotence

\_\_\_\_\_ Painful urination

\_\_\_\_\_ Prostate problems

\_\_\_\_\_ STD's

**Neurological**

\_\_\_\_\_ Concussions

\_\_\_\_\_ Dizziness

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Epilepsy

\_\_\_\_\_ Migraines

\_\_\_\_\_ Numbness

\_\_\_\_\_ Phobophobia

**Lung & Respiration**

\_\_\_\_\_ Asthma

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Bronchitis

\_\_\_\_\_ COPD

\_\_\_\_\_ Pneumonia

\_\_\_\_\_ Valley Fever

**Skin Health**

\_\_\_\_\_ Birth marks

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Eczema

\_\_\_\_\_ Moles

\_\_\_\_\_ Rashes

\_\_\_\_\_ Warts

**Bones & Structural Health**

\_\_\_\_\_ Arthritis

\_\_\_\_\_ Back pain

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Head injuries

\_\_\_\_\_ Muscle spasms

\_\_\_\_\_ Pain in joints

\_\_\_\_\_ Ringing in ears

\_\_\_\_\_ Sciatica

\_\_\_\_\_ TMJ

