Adult Health History Form
Kristin Stiles Green, NMD

Name _____ Date _____

Age _____ Date of Birth _____ Gender: female ____ male _____

Address_____ Zip _____

Phone #'s _____

E-mail address _____

Is any other family member already seeing us? _____

Person(s) to reach in an emergency _____

Relationship(s) _____ Phone #'s_____

May I thank someone for referring you to me? _____

HEALTH HISTORY QUESTIONNAIRE

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PROVIDER HAS A COMPLETE UNDERSTANDING OF THE PERSON PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PLEASE, PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Are you hypersensitive or allergic to:
Any drugs? _____
Any foods? _____
Any environmental things? _____

Do you use tobacco, currently? Y N Smoked previously? Y N
How much, how often? _____
How many years? _____
How many packs per day? _____

Are you currently receiving healthcare? Yes No

If yes, where and from whom? _____

For what reason(s)? _____

What are your most important health problems or goals? Please, list in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

Do you have a diagnosed illness or disease now (or in your past) that we should list as a part of your health history?

_____

Current Medications

Please list ALL prescription medications, over the counter medications, vitamins, herbs, or other supplements you are taking, on a regular basis. **Please include ingredients, milligram amounts, how often taken, etc. PLEASE BRING IN THE BOTTLES OR LABELS**.

_____

_____

_____

_____

_____

_____

_____

_____

GENERAL

Weight today _____lbs.

Maximum weight _____ lbs.

Weight one year ago? _____lbs.

When? _____

Desired weight _____lbs.

Height_____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Hospitalizations and Surgery

What surgeries have you had and when?

_____

When have you been hospitalized and what for?

_____

Special Studies

What imaging or other special studies have you had pertaining to your current problems(s), within the past year?

_____

Screenings:

Date of last Physical Exam? _____ Colonoscopy? _____ **Males:** Prostate Exam? _____

Females: Date of Last PAP? _____ Mammogram? _____ Concerns? _____

FAMILY HISTORY

Please note if any of these disease/problems are or were applicable to your parents, grandparents, uncles, aunts, siblings or children. Please note for whom it was a problem.

Cancer
Diabetes
Heart Disease
High Blood Pressure
Strokes
Mental Illness

Are your parents, grandparents, siblings and children all still living? If not, please note their cause of death and at what age(s), if known?

_____

SOCIAL HISTORY

Live with: Spouse Partner Parents Children Friends Alone

Single Married Divorced Significant partnership Widowed

Occupation _____

Hours per week _____ Retired? _____

Employer _____

For the following sections, please use this key:

Y= a condition you have now N= a condition you have never had P= had in the past

Main interests and hobbies: _____

Do you exercise? YES or NO If yes, what kind? _____

How often? _____How much time spent per week? _____

Average 7-8 hours of sleep?	Y	N	Do you enjoy your work?	Y	N
Sleep well?	Y	N	Take vacations?	Y	N
Awaken rested?	Y	N	Spend time outside?	Y	N
Have a supportive relationship?	Y	N	Watch television?	Y	N
Have a history of any abuse?	Y	N	How many hours/day? _____		
Any major traumas?	Y	N	Read?	Y	N
Do you eat at least three meals a day?	Y	N	How many hours/day? _____		
Do you eat out often?	Y	N	Use alcoholic beverages?	Y	N
Do you go on diets often?	Y	N	How much, how often? _____		
Do you drink coffee?	Y	N	Treated for alcoholism/drug addiction?	Y	N
Do you drink black or green tea?	Y	N	Do you drink cola or other sodas?	Y	N
Do you eat refined sugar?	Y	N	Do you add salt to your food?	Y	N

Are you sexually active? Y N

Any sexual difficulties? _____

Do you have children? Please list names, sex, and ages.

_____

Do you travel often for work? Y N

Any remote locations or 3rd world countries? _____

Are you exposed to any chemicals of occupational hazards as a part of your day or work?

_____

Do you have any pets? If so, please list type.

_____

MOUTH AND THROAT

Frequent sore throat?	Y P N	Teeth grinding?	Y P N
Sore tongue/lips?	Y P N	Gum problems?	Y P N
Hoarseness?	Y P N	Dental problems?	Y P N

SEASONAL ALLERGIES

Stuffiness?	Y P N	Sneezing?	Y P N
Chronic mucus production?	Y P N	Itchy eyes?	Y P N
Itchy ears	Y P N	Loss of smell?	Y P N

CARDIOVASCULAR

Heart disease/heart attack?	Y P N	Angina/chest pain?	Y P N
High cholesterol?	Y P N	Murmurs/valve problems?	Y P N
Blood clot history?	Y P N	Palpitations/Fluttering?	Y P N
High blood pressure/strokes?	Y P N	Swelling in ankles/feet?	Y P N

SKIN

Rashes, Eczema, or Hives?	Y P N	Acne or Boils?	Y P N
Itching?	Y P N	Perpetual hair loss?	Y P N
Unusual lumps/lesions/moles?	Y P N	Night sweats?	Y P N

ENDOCRINE

Hypo or hyperthyroid?	Y P N	Heat or cold intolerance?	Y P N
Hypoglycemia?	Y P N	Diabetes?	Y P N
Excessive thirst or hunger?	Y P N	Cold hands or feet?	Y P N
Fatigue?	Y P N	Seasonal depression?	Y P N

NOSE AND SINUSES

Frequent colds?	Y P N	Nose bleeds?	Y P N
Stuffiness?	Y P N	Hay fever?	Y P N
Sinus problems?	Y P N	Loss of smell?	Y P N

BLOOD/PERIPHERAL VASCULAR

Easy bleeding or bruising?	Y P N	Anemia history?	Y P N
Varicose veins?	Y P N	Circulatory problems?	Y P N

GASTROINTESTINAL

Trouble swallowing?	Y P N	Heartburn/Reflux?	Y P N
Change in thirst?	Y P N	Change in appetite?	Y P N
Nausea/vomiting?	Y P N	Bowel Movements HOW OFTEN? _____	
Blood in stool?	Y P N	Is this a change? _____	
Pain or cramps (not menstrual)?	Y P N	Constipation?	Y P N
Belching or passing gas?	Y P N	Diarrhea?	Y P N
Gallbladder problems?	Y P N	Hemorrhoids?	Y P N
Ulcer history?	Y P N	Liver Disease?	Y P N

MUSCULOSKELETAL

Joint pain or stiffness?	Y P N	Arthritis?	Y P N
Muscle spasms or cramps?	Y P N	Sciatica?	Y P N
Osteopenia/osteoporosis?	Y P N	Bone density study? Y P N	Date _____

NEUROLOGICAL

Seizures?	Y P N	Paralysis?	Y P N
Muscle weakness?	Y P N	Numbness or tingling?	Y P N
Loss of memory?	Y P N	Vertigo or dizziness?	Y P N

EYES

Visual disturbances?	Y P N	Cataracts?	Y P N
Impaired vision?	Y P N	Glasses or contacts?	Y P N
Eye pain/strain?	Y P N	Tearing or dryness?	Y P N
Glaucoma?	Y P N		

MENTAL/ EMOTIONAL

Psychological difficulties?	Y P N	Depression?	Y P N
Mood Swings?	Y P N	Anxiety or nervousness?	Y P N
Considered or attempted suicide?	Y P N	Tension/Easily stressed?	Y P N
Poor concentration?	Y P N	Memory problems?	Y P N

RESPIRATORY

Cough?	Y P N	Wheezing	Y P N
Asthma?	Y P N	Bronchitis?	Y P N
Pneumonia?	Y P N	Emphysema?	Y P N
Difficulty breathing?	Y P N	Tuberculosis history?	Y P N
Shortness of breath?	Y P N		

URINARY

Pain on urination?	Y P N	Increased frequency?	Y P N
Inability to hold urine?	Y P N	Kidney stones?	Y P N
Frequent infections?	Y P N		

IMMUNE

Cancer history?	Y P N	Reactions to vaccinations?	Y P N
Chronic Fatigue Syndrome?	Y P N	Chronic infections?	Y P N
Chronically swollen glands?	Y P N	Slow wound healing?	Y P N

HEAD

Headaches?	Y P N	Head injury history?	Y P N
Migraines?	Y P N	Jaw/TMJ problems	Y P N

EARS

Impaired hearing?	Y P N	Ringing?	Y P N
Earaches?	Y P N	Dizziness?	Y P N

NECK

Lumps?	Y P N	Swollen glands?	Y P N
Goiter?	Y P N	Pain or stiffness?	Y P N

MALE REPRODUCTION

Hernia history?	Y P N	Testicular masses?	Y P N
Testicular pain?	Y P N	Prostate problems?	Y P N
Sexually transmitted diseases?	Y P N	Any discharge or sores?	Y P N
		Birth control_____	

FEMALE REPRODUCTION

Age of first menses? _____
Age/date of last menses? _____
Length between periods? _____days
Are cycles regular? Y P N
Duration of bleeding/period? _____days
Bleeding between periods? Y P N
Painful menses? Y P N
Heavy or excessive flow? Y P N
PMS? Y P N
If yes, what are your symptoms?

_____

_____

Endometriosis? Y P N
Ovarian cysts? Y P N
Fibroid tumors Y P N
Fertility problems Y P N
Sexually transmitted diseases? Y P N

Birth control? Y N
What type? _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____

Abnormal PAP history? Y P N
Cervical dysplasia? Y P N
Have you had any gynecological surgeries?

_____

Menopausal symptoms? Y P N
Do you do breast self-exams? Y P N
Have breast lumps? Y P N
Breast pain or tenderness? Y P N
Nipple discharge? Y P N
Fibrocystic breasts? Y P N
Last PAP smear/Pelvic exam? _____

Do you have a spiritual practice? Yes/No _____

When during the day is your energy the best? _____ the worst? _____

How do your current conditions affect you?

_____

_____

What do you think is happening? _____

Any idea why? _____

What do you feel needs to happen for you to feel better/get better?

_____

_____

What do you enjoy most in your life? _____

_____

How much change are you willing to make at this time for improving your health?

MINIMAL? SOME? COMPLETE?

Is there any information about your health that you would like to add?

_____

_____

I certify that the information given on this form is true and correct. I understand that this information will be used for the purposes of naturopathic medical consultation I acknowledge by my signature that I have read and understand these statements.

Signature Date

Welcome!

We are glad to serve you!