



## Family Health History

Please list your family members' current age and any medical conditions they have had.

<u>Family Member</u>	<u>Age</u>	<u>Medical Condition(s)</u>
Mother:	_____	_____
Father:	_____	_____
Siblings:	_____	_____

Are there any conditions that run in your extended family?

## Physical Health Information

Circumstances of your **birth** :       premature     prolonged labor     forceps delivery     drug induced delivery     C-section

Did your mother smoke / drink / take drugs / experience trauma when pregnant with you?      Please explain:

Did either of your parents smoke when you were growing up?

Immunizations / vaccinations:

Health problems / illnesses for which you have had medical treatment :      Please provide approximate dates.

Please describe and give approximate dates for the following:

accidents       hospitalizations       surgeries       blood transfusions       significant blood loss

Any history of sexually transmitted disease(s)?      Treatments Used:

Drug sensitivities or reactions?

Substance abuse of any kind?

Recreational drug use:      Drug(s) of choice in the Past:      Use:     Casual     Moderate     Excess

Present:      Use:     Casual     Moderate     Excess

**History of Exercise?**      What kind(s)?      How often?

Please rate your overall **energy level** on a scale of one to ten (one is lowest)    1 2 3 4 5 6 7 8 9 10

Are there times of the day when you feel especially  tired      What time:  
 energetic      What time:

Have you ever had **sleep problems?**       past     present      Please describe:

Have you ever used any sleeping aides (drugs, supplements, self help techniques, etc.)?      Which ones?

Has your job schedule or home environment ever interfered with normal sleep patterns?      How so and for how long?

What time do you usually go to sleep at night?      What time do you usually wake up in the morning?

Have you had any trouble falling asleep?      What keeps you awake?

Have you often awoken during the night?      What has woken you up?      What time do you wake?

Have you had trouble falling back to sleep after you have awoken?      What do you do to fall asleep?

Do you wake feeling rested?      Do you have trouble waking / getting out of bed in the morning?

Have your dreams disturbed your sleep?	What type of dreams bother you?
Do you snore?	Do you have sleep apnea (stop breathing while sleeping)?
Do you sleep-walk or sleep-talk?	
Do you nap during the day?	How frequently and for how long?
What is your overall feeling of your <b>body temperature</b> ? Do you typically feel: <input type="checkbox"/> hot <input type="checkbox"/> cold <input type="checkbox"/> fluctuates <input type="checkbox"/> normal / stable	
Do you feel you are <b>heat or cold sensitive</b> ?	
When do parts of your body feel: <input type="checkbox"/> colder	<input type="checkbox"/> warmer
Do you feel better or worse in certain conditions / times of the year? (heat, cold, humidity, dryness, wind; winter, spring summer, fall)	
Do you <b>perspire</b> :	
<input type="checkbox"/> normally	<input type="checkbox"/> little or not at all
<input type="checkbox"/> at night	<input type="checkbox"/> cold sweats
<input type="checkbox"/> only under exertion	<input type="checkbox"/> spontaneously
<input type="checkbox"/> unusual odor	<input type="checkbox"/> more than average
<input type="checkbox"/> Other:	<input type="checkbox"/> excessively
Do you use antiperspirants / deodorants?	Do they contain aluminum?
Do you have any <b>acute or chronic pain</b> problems?	Please describe location(s):
Please <b>describe sensations of pain</b> as best as you can: <input type="checkbox"/> intense <input type="checkbox"/> sharp <input type="checkbox"/> burning <input type="checkbox"/> boring <input type="checkbox"/> tearing <input type="checkbox"/> piercing	
<input type="checkbox"/> stabbing <input type="checkbox"/> dull <input type="checkbox"/> aching <input type="checkbox"/> heavy <input type="checkbox"/> cramping <input type="checkbox"/> fixed <input type="checkbox"/> moving <input type="checkbox"/> comes and goes <input type="checkbox"/> constant <input type="checkbox"/> throbbing	
<input type="checkbox"/> spontaneous <input type="checkbox"/> painful with pressure <input type="checkbox"/> accompanied by swelling <input type="checkbox"/> radiates to:	
<input type="checkbox"/> Other (please describe):	
Have you experienced any <b>numbness or tingling</b> anywhere in your body?	<input type="checkbox"/> past <input type="checkbox"/> present If so: where and when?
<input type="checkbox"/> Neuropathy?	
<b>Skin:</b> <input type="checkbox"/> dryness <input type="checkbox"/> itching <input type="checkbox"/> rashes <input type="checkbox"/> acne <input type="checkbox"/> hives <input type="checkbox"/> moles <input type="checkbox"/> warts <input type="checkbox"/> ulcerations	
<input type="checkbox"/> sensitivity <input type="checkbox"/> birthmarks <input type="checkbox"/> varicose veins <input type="checkbox"/> dandruff <input type="checkbox"/> itchy scalp <input type="checkbox"/> psoriasis <input type="checkbox"/> eczema <input type="checkbox"/> dermatitis	
<input type="checkbox"/> color changes <input type="checkbox"/> bruise easily <input type="checkbox"/> Other:	
Do you use lotion?	What kind? (brand):
Do you use sun screen?	What kind? (brand and SPF):
Do you use artificial tanning products or tanning beds?	How often: Where on your body: How often?
<b>Body Modification (Tattoo / Piercing) / Cosmetic Surgery:</b>	
<b>Scars:</b> Cause and Location:	Do any of your scars bother you?
<b>Hair:</b> Is your hair naturally: <input type="checkbox"/> straight <input type="checkbox"/> curly <input type="checkbox"/> kinky <input type="checkbox"/> dry <input type="checkbox"/> brittle <input type="checkbox"/> oily	
<input type="checkbox"/> growth rate (fast / slow / normal) <input type="checkbox"/> hair loss <input type="checkbox"/> early graying / whitening <input type="checkbox"/> use of chemicals for hair	
<b>Nails:</b> <input type="checkbox"/> dry / brittle <input type="checkbox"/> soft / hard <input type="checkbox"/> growth rate (fast / slow/ normal) <input type="checkbox"/> ridges <input type="checkbox"/> white specks <input type="checkbox"/> discoloration	
<input type="checkbox"/> fungal problems (where?) <input type="checkbox"/> misshapen <input type="checkbox"/> use of nail polish / remover <input type="checkbox"/> Other:	
Any <b>eye / vision</b> complaints?	Do you wear glasses or contact lenses?
<input type="checkbox"/> redness <input type="checkbox"/> itchiness <input type="checkbox"/> watery <input type="checkbox"/> blurry <input type="checkbox"/> heat in the eyes <input type="checkbox"/> light sensitivity	
<input type="checkbox"/> dryness <input type="checkbox"/> poor night vision <input type="checkbox"/> glaucoma <input type="checkbox"/> cataracts <input type="checkbox"/> macular degeneration <input type="checkbox"/> color blindness	
<input type="checkbox"/> floaters (objects floating across field of vision) <input type="checkbox"/> grit in the eyes <input type="checkbox"/> near or farsightedness <input type="checkbox"/> Other:	
Any <b>ear / hearing</b> problems?	<input type="checkbox"/> ringing in the ears <input type="checkbox"/> hearing difficulties <input type="checkbox"/> excessive wax <input type="checkbox"/> sensitivity to sounds
<input type="checkbox"/> discharge <input type="checkbox"/> recurring / chronic earaches or infections <input type="checkbox"/> ear tubes / implants <input type="checkbox"/> Other:	
<b>Teeth:</b> <input type="checkbox"/> history of extensive dental work (born with extra teeth, extractions, braces, etc.) <input type="checkbox"/> mercury amalgam replacement	
number of fillings: ___mercury (silver)amalgam ___composite ___gold <input type="checkbox"/> root canals <input type="checkbox"/> bridges	
<input type="checkbox"/> crowns <input type="checkbox"/> sensitivity to temperature (hot or cold / sugar) <input type="checkbox"/> looseness of teeth <input type="checkbox"/> discoloration of teeth	
<b>Gums:</b> <input type="checkbox"/> bleeding <input type="checkbox"/> receding <input type="checkbox"/> gingivitis <input type="checkbox"/> sores / ulcers <input type="checkbox"/> periodontal disease <input type="checkbox"/> Other:	
<b>Mouth / Tongue:</b> <input type="checkbox"/> sores / ulcers <input type="checkbox"/> bad breath <input type="checkbox"/> thick coating on the tongue (please describe color, etc.):	
<input type="checkbox"/> tongue sensitivity <input type="checkbox"/> Other:	



Have you had any significant exposure to <b>second hand smoke</b> ?		
How often do you contract a common cold / flu?	How recently have you been exposed to or have had a cold / flu?	
Do you have sensitivities or reactions to any chemicals?		
<hr/>		
How many times during the day do you <b>urinate</b> ?	How many times at night?	
Color / quality of your urine:		
<input type="checkbox"/> 'normal' <input type="checkbox"/> clear <input type="checkbox"/> dark yellow <input type="checkbox"/> reddish (blood) <input type="checkbox"/> cloudy <input type="checkbox"/> foamy <input type="checkbox"/> odorous <input type="checkbox"/> burning / painful <input type="checkbox"/> difficult <input type="checkbox"/> hesitant <input type="checkbox"/> dribbling <input type="checkbox"/> retention <input type="checkbox"/> urgent <input type="checkbox"/> frequent <input type="checkbox"/> weak stream <input type="checkbox"/> bed wetting <input type="checkbox"/> incontinence (lack of control with jumping / laughing / coughing / sneezing, etc.) <input type="checkbox"/> Other:		
<hr/>		
Any history of kidney and/or urinary tract infections?	Frequency:	
<hr/>		
Any history of kidney stones?	Frequency:	When did you last have kidney stones?
<hr/>		
Do you have regular <b>bowel movements</b> ?	How many each day?	Week?
<hr/>		
What time(s) of day do you normally have a bowel movement?		
<hr/>		
Do you experience <b>constipation</b> or <b>diarrhea</b> ?	<input type="checkbox"/> past <input type="checkbox"/> present	
<hr/>		
What is the consistency of your stools:	<input type="checkbox"/> well formed <input type="checkbox"/> hard / pellets <input type="checkbox"/> loose / unformed <input type="checkbox"/> alternating consistency	
<hr/>		
Color of stool:	<input type="checkbox"/> brown <input type="checkbox"/> yellow/tan <input type="checkbox"/> black <input type="checkbox"/> red (blood) <input type="checkbox"/> white/grey <input type="checkbox"/> green <input type="checkbox"/> alternates	
<hr/>		
Any mucous regularly in the stool?	Color of mucous: <input type="checkbox"/> clear <input type="checkbox"/> white <input type="checkbox"/> yellow <input type="checkbox"/> green / brown	
<hr/>		
Any difficulty passing stools?	Any pain associated with passing stool?	<input type="checkbox"/> before <input type="checkbox"/> during <input type="checkbox"/> after
<hr/>		
Do you have a feeling of incomplete evacuation after passing stools?		
<hr/>		
Have you ever used laxatives?	<input type="checkbox"/> past <input type="checkbox"/> present <input type="checkbox"/> intermittent <input type="checkbox"/> long term	Which types / brands?
<hr/>		
Have you used a stool softener or fiber product?	<input type="checkbox"/> past <input type="checkbox"/> present	What brand and how often?
<hr/>		
Have you used enemas or colonics?	<input type="checkbox"/> past <input type="checkbox"/> present	How frequently?
<hr/>		
Have you suffered from <b>hemorrhoids</b> or <b>fissures</b> ?	<input type="checkbox"/> past <input type="checkbox"/> present	
<hr/>		
Have you ever experienced:		
<input type="checkbox"/> palpitations <input type="checkbox"/> fast/slow heart rate <input type="checkbox"/> arrhythmia <input type="checkbox"/> fibrillations <input type="checkbox"/> heart disease <input type="checkbox"/> blood clots <input type="checkbox"/> phlebitis <input type="checkbox"/> rheumatic fever <input type="checkbox"/> fainting <input type="checkbox"/> ankle swelling <input type="checkbox"/> heart murmur <input type="checkbox"/> angina/chest pain <input type="checkbox"/> heart related surgery <input type="checkbox"/> bleeding/clotting disorders <input type="checkbox"/> Other:		
<hr/>		
How frequently (daily, weekly, monthly)?	Do they occur in relation to any particular activity?	
<hr/>		
How long do they last when they do occur (seconds, minutes, hours)?		
<hr/>		
Have you ever had: <input type="checkbox"/> low blood pressure <input type="checkbox"/> high blood pressure		
<hr/>		
Have you ever had elevated cholesterol?		
<hr/>		
Do you ever have any unusual swelling in your arms or legs?		
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<b>WOMEN ONLY   IMPORTANT: REGARDLESS OF AGE AND STAGE OF LIFE</b>		
<b>PLEASE RESPOND TO THE FOLLOWING QUESTIONS ABOUT YOUR HEALTH – PAST AND/OR PRESENT</b>		
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Age of first menses (menarche):	Dates of last period:	Are you currently trying to get pregnant?
<hr/>		
Date of last gynecological exam:	Date of last PAP smear:	
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Number of pregnancies:	Number of abortions (dates):	Number of miscarriages (dates):
<hr/>		

Have you had any difficulties with conception?		If yes, please describe:	
Have you had any Laparoscopies?	When?	Why?	
Do you want to have (more) children?			
Any birthing difficulties? <input type="checkbox"/> C-section <input type="checkbox"/> premature <input type="checkbox"/> prolonged <input type="checkbox"/> hemorrhaging <input type="checkbox"/> ectopic pregnancy <input type="checkbox"/> severe pain <input type="checkbox"/> induced labor <input type="checkbox"/> Other (please describe):			
Have you had postpartum depression?	Postpartum weakness?	Other postpartum complications?	
Have you ever used birth control drugs or practiced birth control methods?		Type(s)?	When and for how long?
Have you had a hysterectomy?	<input type="checkbox"/> Partial <input type="checkbox"/> Complete	Date:	Reason for hysterectomy:
Have you had menopausal symptoms?	Since when?	Please describe:	
Have you ever used hormone replacement therapy?		For what and for how long?	
Have you ever missed periods (other than when pregnant / lactating)?		If so, please describe:	
Has your cycle always been regular?		If not, please explain:	
How many days between the start of each cycle?		How many days do/did you typically flow?	
Please describe the quantity and quality of the flow: <input type="checkbox"/> light <input type="checkbox"/> normal <input type="checkbox"/> heavy <input type="checkbox"/> clotting <input type="checkbox"/> Other: <input type="checkbox"/> pale <input type="checkbox"/> bright red <input type="checkbox"/> dark red <input type="checkbox"/> brown			
Have you ever had unusual bleeding / spotting or vaginal discharge between periods or otherwise?			
Have you experienced pain / cramps associated with your period? <input type="checkbox"/> before period <input type="checkbox"/> during period <input type="checkbox"/> after period		For how many years? <input type="checkbox"/> mild <input type="checkbox"/> strong <input type="checkbox"/> intense / debilitating	
The pain was / is reduced with: <input type="checkbox"/> warmth / heat <input type="checkbox"/> rest / inactivity <input type="checkbox"/> activity / movement <input type="checkbox"/> start of period <input type="checkbox"/> drugs (name): <input type="checkbox"/> Other:			
Have you experienced any of the following before or during your period? <input type="checkbox"/> water retention <input type="checkbox"/> breast tenderness / swelling <input type="checkbox"/> fatigue <input type="checkbox"/> emotional ups / downs <input type="checkbox"/> depression <input type="checkbox"/> irritability <input type="checkbox"/> headaches <input type="checkbox"/> nausea/vomiting <input type="checkbox"/> low back pain <input type="checkbox"/> change in bowel habits <input type="checkbox"/> food cravings <input type="checkbox"/> Other:			
Any vaginal dryness or itching?	Bleeding and / or pain during or after intercourse?	Libido issues?	
Any history of: <input type="checkbox"/> Yeast infections <input type="checkbox"/> Pelvic inflammatory disease <input type="checkbox"/> Endometriosis			
How frequently do you have breast exams / mammograms?		Have you ever had lactation difficulties?	
Have you had any breast lumps / cysts / fibroids?		Any bleeding or discharge from nipples?	
<b>MEN ONLY</b>			
Have you ever had any prostate problems?		If so, please describe:	
Ever had a vasectomy?	When?	Reversal of vasectomy?	
Any physical problems with the penis / scrotum / testicles (masses / cysts / tumors)?			
Any sensations of <input type="checkbox"/> coldness <input type="checkbox"/> numbness <input type="checkbox"/> pain?		Any swelling?	



# DIET AND NUTRITION

Were you breastfed? If so, for how long?

Please describe your **diet** in your youth:

Please describe your present diet:  vegetarian  vegan  carnivore  omnivore  low salt  low fat  low sugar  
 low carbohydrate  low protein  high protein  Other:

Have you followed any diets? Please describe the diet, diet objectives, length of time you adhered to it and the result:

Any experience with cleanses/detoxification programs or fasting?

Do you eat regular meals? Do you skip meals? If so, which one(s), how often and why?

Do you snack between meals? Typical snack foods:

Do you eat near bedtime or at night?

How often do you eat out?  past  present Where / what type of food when dining out:

What percentage of your food intake is raw?

Do you like to cook? Do you actually cook much? Do you enjoy eating?

Do you cook with:  Aluminum pots  Stainless Steel pots  Non-stick pots  Cast Iron pots  
 Clay pots  Stoneware  Glass / Pyrex  Other:

Are you relaxed when you eat? Do you usually eat in a relaxed environment?

Do you often eat while:  reading  watching TV  driving  standing up  talking  Other:

Any history of eating disorders, emotional or binge eating? Please describe:

Do you crave any of the following foods?  sweets  breads  fatty foods  meats  fish  milk  Other:

What do you usually drink with food / meals?  cold fluids  warm fluids  hot fluids Please List:

Which tastes do you prefer:  sweet  salty  sour  pungent / spicy-hot  bitter  astringent

Do you strongly dislike any particular tastes or foods?

Have you used any artificial sweeteners? Which ones, how much and for how long?

How would you describe your **appetite**:  normal  weak  strong  variable  constant

What factors cause appetite to vary and how so?  
 exercise  caffeine  medication  stress  time of day / month (when ?)  weather /season  Other:

How do you generally feel after eating? Does your energy level go:  up  down  stay the same?

Does it depend on the type and / or amount of food eaten? Which foods cause which reaction?

What are your favorite foods? What foods do you eat regularly?

Please describe your **typical daily meals / snacks** and the **times** you eat them. \*Please indicate your largest meal of the day.

Time	Meal	Foods / beverages
__:__ am	<b>Breakfast:</b>	
	Snacks (after breakfast):	
__:__ am / pm	<b>Lunch:</b>	
	Snacks (after lunch):	
__:__ pm	<b>Supper/Dinner:</b>	
	Snacks (after dinner):	
__:__ pm	After Supper/before sleep:	

Please indicate (circle and / or check) **liquid intake** amounts (ounces):

___ Ounces per day / week / month	<input type="checkbox"/> Water ( <input type="checkbox"/> tap <input type="checkbox"/> bottled <input type="checkbox"/> filtered/purified )
___ Ounces per day / week / month	<input type="checkbox"/> Coffee ( <input type="checkbox"/> caffeinated <input type="checkbox"/> decaffeinated )
___ Ounces per day / week / month	<input type="checkbox"/> Teas ( <input type="checkbox"/> caffeinated <input type="checkbox"/> decaffeinated <input type="checkbox"/> herbal ) Which types of herbal teas:
___ Ounces per day / week / month	<input type="checkbox"/> Soft drinks (type):
___ Ounces per day / week / month	<input type="checkbox"/> Alcohol (type of alcohol: <input type="checkbox"/> beer <input type="checkbox"/> wine <input type="checkbox"/> hard liquor )
___ Ounces per day / week / month	<input type="checkbox"/> Juice (please give types):
___ Ounces per day / week / month	<input type="checkbox"/> Other [energy drinks, etc.]:

Which **fats / oils** do you use?

- margarine  butter / ghee  olive  safflower  sunflower  corn  Crisco  canola  grape seed  
 coconut  peanut  soybean  sesame  mayonnaise  flax  lard  fish/cod liver  Other:

Do you have any **digestive complaints**?

- bad breath  intestinal gas  foul gas  belching  hiccups  bloating  nausea/vomiting  
 abdominal cramping  pain (where?)  pain relieved by passing gas?  noisy stomach / intestines (gurgling, etc.)  
 heart burn  acid reflux / regurgitation (GERD)  hiatal hernia  burning pain after eating  
 jaundice  gall bladder disease  liver disease (fatty liver, cirrhosis, hepatitis)  IBS  ulcers  Other:

Do you have any **food sensitivities or allergies**?

Have you had any problems with **blood sugar fluctuations** (hypoglycemia, insulin resistance, diabetes, etc.)?

Do you chew **gum**? If so, what kind, how often, and since when?

Do you **chew your food** well or "inhale" it?

Would you like to **decrease / increase** your **body weight**? If so, by how much?

When did you last have a significant (more than 10 pounds) **change in weight**?

Please list any other health concerns you wish to address that have not been covered in this questionnaire:

Thank you for taking the time and effort to fill out this form. We look forward to working with you.

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

