GLAD HEALTH

CONFIDENTIAL HEALTH HISTORY

Date _____

Personal History

Name: _____ Date of Birth____/____/_____(mm/dd/yyyy) Age_____

Occupation _____ Birthplace_____(City & Country)

Height_____inches Weight_____(lbs or Kg)

Referred by:_____

ALLERGIES: Like – Food, Pollens, Odors, Medicines, Pets etc…

_____

_____

_____

MAIN PROBLEMS/ REASONS FOR THIS CONSULTATION: **(if possible, rank in terms of importance to you)**

1. _____
2. _____
3. _____
4. _____
5. _____

Additional problems or concerns you would like to be addressed:

_____

_____

_____

_____

_____

*Note: we may not be able to address every problem during the course of one treatment.

Current Medications	Dose	Times / Day

Current Herbs / Vitamins/ Homeopathy/ Supplements	Dose	Times / Day

PAST MEDICAL, SURGICAL & TRAUMA HISTORY Patient Name:

List prior illness, injury, hospitalization, surgery, and/or trauma:

Reason: **Date/Month and Year**

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							

Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other							

SOCIAL HISTORY (check those that apply): **Patient Name:**

Marital status:
single
married
divorced
Widowed

Education level completed:
high school
college
professional school
other:

Memories of your childhood
Mostly happy
Mostly painful
Normal
Don't recall

Do You Find Your Life
Generally Unsatisfactory
Too Demanding
Boring
Satisfactory
More than satisfactory

Living arrangement:
alone family roommate significant other
children (list sex/ages):_____
Major stresses in last 2 years Money Job Marriage Home Life Children Health
other stress_____

Pertinent travel history: (out of USA, epidemic areas)

_____
_____

LIFESTYLE / SELF-CARE ISSUES

Do you smoke cigarettes?	YES	NO	If yes, how many? #_____yrs. _____ packs per day
Did you ever smoke?	YES	NO	If yes, when did you quit? _____
Do you drink alcohol?	YES	NO	If yes, how much? Type_____ & _____ drinks per week
Do you drink caffeine beverages?	YES	NO	If yes, which? _____
Do you use recreational drugs?	YES	NO	If yes, which? _____
Do you manage stress well?	YES	NO	NOT SURE NEED HELP
Do you exercise regularly?	YES	NO	If no, why? _____
Do you enjoy your job?	YES	NO	If no, why? _____
Do you allow time to unwind and relax?	YES	NO	If no, why? _____
Do you sleep soundly?	YES	NO	If no, why? _____
Are you satisfied with your sex life?	YES	NO	If no, why? _____
Are you satisfied with your social life?	YES	NO	If no, why? _____
Are you satisfied with your spiritual life?	YES	NO	If no, why? _____
Is your diet healthy enough?	YES	NO	NOT SURE NEED HELP

Typical breakfast_____

Typical lunch _____

Typical dinner_____

Typical snacks_____

What has been your past experience with weight management?

_____

_____

_____

Who does the grocery shopping for your household?_____

Who does the cooking?_____

How many nights per week do you eat in restaurants?_____ # Take-out meals per week?_____

Frequent restaurants : _____ Frequent Take-out:_____

_____ _____

_____ _____

_____ _____

Are there foods you avoid? Why?

_____ _____

_____ _____

_____ _____

_____ _____

What do you do for exercise? Minutes per week: Regularly?

_____ _____ _____

_____ _____ _____

_____ _____ _____

Blood test for : Total Cholesterol_____ HDL_____ LDL _____ Triglycerides_____ (Date_____)

Blood Sugar _____ (fasting / non-fasting) (Date_____)

Other Blood tests / Dates_____

Do you have lifestyle modification goals? Please list :

_____

_____

_____

_____

REVIEW OF SYSTEMS **Patient Name:**

Check any symptoms that currently apply to you:

Constitutional
___ poor appetite
___ fevers
___ chills
___ food craving
___ weight loss
___ weight gain
___ fatigue

Eyes
___ eye pain
___ blurred vision
___ poor vision___day
___ poor vision___night
___ wear corrective lenses
___ near____far sighted
___ other

Ears, Nose
___ ringing ears
___ nosebleed/polyp
___postnasal drip
___sinus problems
___trouble with taste/smell
___poor hearing
___earaches/ infections
___sneezing/ discharges

Mouth, Throat
___ tongue discoloration
___ bad breath
___ teeth problems
___ grinding teeth
___ tonsillitis/ adenoids
___ facial pain
___ sore throat
___ ulceration tongue
___ gum bleeding

Heart & Circulation
____chest pain
____ lightheadedness
___ palpitations
____ cold hands/feet
____ fainting
____ swelling feet
____ blood clots
____ varicose veins

Breathing & Lungs
____shortness of breath
____wheezing or asthma
____repeated colds/ flu
_____ cough dry/ irritating

Muscles, Bones & Joints
____neck pain
____back pain
____muscle pain
____ painful joints: R__L__
____shoulder ____elbow
____hip____ knee ___ankle
____wrist _____fingers
____joint swelling
____muscle weakness
____muscle cramps

Skin, Hair
____ psoriasis
____ warts
____ freckles
____ itching, hives
____ hair loss
____ dry skin, eczema

Nerves, Movement, Brain
_____ seizures
_____nerve pain
_____poor balance
_____poor coordination
_____tremors or shaking
_____headaches

Digestion & Intestines
____indigestion
____belching/ flatulence
____difficulty swallowing
____heartburn/ ulcer
____nausea
____ liver trouble
____ vomiting
____ diarrhea
____ cramping bowels
____ food allergies
____constipation
____ abdominal pain
____rectal pain/ itching
____ hemorrhoids/ piles
____ blood in stool

Urine, Kidney, Bladder
____painful urination
____wake up to urinate
_____kidney stones
____ loss of control
____ frequent urination
____ sudden urging
____ blood/pus urine
____urine infection UTI

Immune System
_____too many infections
____allergies to food
____allergies to environment
___ other concerns

Blood System
____lymph gland swelling
____anemia
____easy bruising

Mind Symptoms
____memory
____temper/anger
____emotional
____sleep

Sexual Organs
____ sores on genitals
____ lumps or swelling
____ erection problems
____ premature ejaculation
_____pain with sex
____infertility
____repeated infections
____aversion to sex

Thermal State
___hot
___chilly

Women
_____ pelvic pain
_____ vaginal discharge
_____ painful periods
_____premenstrual syndrome
_____ hot flashes
_____ itching or soreness
_____irregular menses
_____leucorrhoea

Reproductive
____age period started
____ # of pregnancies
____# abortions
____# miscarriages
____# live births
___children currently living
___age menopause ___
___past infertility

Additional Symptoms --

_____

_____

_____

_____

Date **Patient/ Guardian signature that filled out the history**

Mailing Address

Phone – _____ _____

Email - _____ _____