Health History

NAME_____ Today's Date ____/____/____

ADDRESS_____ CITY_____STATE_____ ZIP_____

Best Phone _____ Secondary phone _____

E-Mail _____

DOB____/____/____ Age_____ Height_____ Weight_____#

Occupation_____ Full-time_____ Part-time_____ Retired_____ Disabled_____

Employer _____

Single_____ Married_____ Divorced_____ Widowed_____ Partnership_____

Name of Spouse/Partner_____

Contact in case of Emergency:_____ Relationship to you_____

Phone (home)_____ Phone (work)_____

Referred to this office by: _____

Addressing the issues that brought you to our office

Main reason (symptom, health condition, etc.) for consulting our office today? _____

_____

When did this health issue initially begin? _____

Since this began, it is… _____Getting Better _____Getting Worse _____Off & On _____Constant

What makes it worse? _____

What makes it better? _____

Is there a time of day that this issue is typically worse? _____Yes _____No If yes, when:_____

Does it interfere with… _____Work _____Sleep _____Walking _____Sitting _____Exercise

Are you unable to do certain activities because of this health issue that you would like to do? (i.e. hobbies, outside activities, gardening, etc.) If so, what?_____

Other doctors/treatments you've tried for this problem: (Please list):

_____Chiropractor: Who?_____When?_____

_____Medical Doctor: Who?_____When?_____

_____Alternative (i.e. massage, energy): Who?_____When?_____

Who is your primary care physician? _____

Mark below if you have, or think you have, *[in the past or present]* any of the following health problems/complaints:

- ❒ Alopecia (hair loss all over)
- ❒ Celiac disease
- ❒ Crohn's disease or Irritable Bowel
- ❒ Eczema
- ❒ Endometriosis
- ❒ Fibromyalgia
- ❒ Grave's disease
- ❒ Hashimoto's disease
- ❒ Hypothyroid symptoms
- ❒ Hypothyroidism (confirmed)
- ❒ Infertility (inability to conceive)
- ❒ Lupus
- ❒ Multiple Sclerosis
- ❒ Parkinson's disease
- ❒ Pernicious anemia
- ❒ Psoriasis
- ❒ Raynaud's syndrome
- ❒ Rheumatoid arthritis
- ❒ Rosacea
- ❒ Scleroderma
- ❒ Sjogren's Syndrome
- ❒ Type I diabetes
- ❒ Ulcerative colitis
- ❒ Vitiligo (a skin condition)

Previous and/or Current Health Challenges

So that we can have a full and complete understanding of your health picture/status, **please write either "P" for past, or "C" for current and "P/C" for both past and current.** If you have **never** experienced a particular condition/symptom, then **leave blank**.

___ Alcoholism
___ Allergies
Food ____ *Seasonal* ____
___ Anemia
___ Anxiety
___ Arteriosclerosis
___ Arthritis
___ Asthma
___ Back/Neck Pain
___ Cancer
___ Cold Feet and/or Hands
___ Depression
___ Diabetes
___ Diarrhea
___ Difficulty Urinating
___ Emphysema
___ Fainting
___ Frequent Colds
___ Gall Bladder Problems
___ Gout
___ Hay fever
___ Headaches
___ Heart Attack
___ Heart Disease
___ Hemorrhoids
___ High Blood Pressure
___ Hip Pain/Knee Pain
___ Indigestion
___ Insomnia (Sleep problems)
___ Loss of Balance
___ Low Blood Pressure
___ Low Blood Sugar
___ Menstrual Cramps
___ Migraines
___ Miscarriage/pregnancy
___ Muscle Spasms
___ Nervousness
___ Neuropathy
___ Numbness
___ Ringing In Ears
___ Shoulder Pain
___ Sinus Problems
___ Smoker –
*How much/day*_____
For How long _____
___ Stiff/Swollen Joints
___ Stroke
___ Thyroid Problems
___ Ulcers, stomach
___ Varicose Veins

If there are any other health challenges or conditions which you've experienced in the past or currently experience, please list & and explain them here: _____

_____

Surgeries:

Any surgeries: (Please include all surgeries [use separate sheet if necessary])

Type_____When_____
Type_____When_____
Type_____When_____
Type_____When_____
Type_____When_____
Type_____When_____

Accidents:

Any past accidents or injuries: auto, work-related, sports injuries, or other:

Type_____When_____Hospitalized: _____Yes _____No
Type_____When_____Hospitalized: _____Yes _____No
Type_____When_____Hospitalized: _____Yes _____No

Because decreasing stress helps with health improvement, when was your last vacation?_____

Do you have a vacation planned over the next 6 – 12 months? ____Yes ____No _____

Do you have or have you ever had cancer? ____Yes ____No
If you marked "yes", briefly explain: _____

If you currently have cancer, are you under active treatment? ____Yes ____No
If you marked "yes", briefly explain: _____

Other Health Information

Please list ALL drugs you currently take or have taken in the past 6 months:

Drug Name	Reason for taking	Duration of use (months/years)	Currently using
Name _____	Reason?_____	Duration? _____	Current use?___
Name _____	Reason?_____	Duration? _____	Current use?___
Name _____	Reason?_____	Duration? _____	Current use?___
Name _____	Reason?_____	Duration? _____	Current use?___
Name _____	Reason?_____	Duration? _____	Current use?___
Name _____	Reason?_____	Duration? _____	Current use?___
Name _____	Reason?_____	Duration? _____	Current use?___
Name _____	Reason?_____	Duration? _____	Current use?___

Please list all nutritional supplements, vitamins you presently take:

Name_____ Reason?_____
Name_____ Reason?_____
Name_____ Reason?_____
Name_____ Reason?_____
Name_____ Reason?_____
Name_____ Reason?_____

- -

On a scale of 1-10 with 1 being minimal and 10 being maximum; what is your commitment level to your health? _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow Dr. Medina to examine me & consult with me for further evaluation. I understand that I am ultimately responsible for payment in full at this office.

Signature:_____ **Date:**_____

(over)

Symptom & Diagnosis Check List

If you have any of the following symptoms or health problems, put a checkmark in the box.

- ❒ **Craving baked goods (cake, cookies, brownies)**
- ❒ Craving high sugar foods
- ❒ Frequent intestinal bloating or gas especially after eating
- ❒ **IBS – irritable bowel syndrome**
- ❒ **Acid reflux – GERD (aka heartburn)**
- ❒ Indigestion
- ❒ Constipation
- ❒ **Diarrhea**
- ❒ **Frequent nausea and or vomiting**
- ❒ Difficulty gaining weight (children under the growth curve)
- ❒ Iron deficiency anemia
- ❒ Frequent headaches
- ❒ Sinus congestion
- ❒ **Migraine Headaches**
- ❒ Poor memory
- ❒ **Vertigo**
- ❒ Difficulty recalling words
- ❒ Brain fog
- ❒ Poor concentration
- ❒ Been diagnosed with ADD or ADHD
- ❒ **Suffer with frequent vertigo (dizziness)**
- ❒ Depression
- ❒ Anxiety
- ❒ Neuropathy
- ❒ Irrational irritability
- ❒ Mood swings
- ❒ Restless leg syndrome
- ❒ **Diagnosed with Chronic Fatigue Syndrome**
- ❒ **Diagnosed with Multiple Sclerosis or Parkinson's**
- ❒ Frequent joint pains with or without activity
- ❒ Chronic muscle aches
- ❒ Migrating joint pain (without injury)
- ❒ Frequent muscle spasms (especially in the legs)
- ❒ **Diagnosed with Fibromyalgia**
- ❒ **Diagnosed with autoimmune arthritis (RA, lupus, psoriatic arthritis, reactive arthritis, ankylosing spondylitis, Sjogren's)**
- ❒ Bone pain
- ❒ Growing pains
- ❒ **Osteoporosis or osteopenia**
- ❒ Fatigue
- ❒ Inability to lose weight
- ❒ Difficulty falling asleep or staying asleep
- ❒ Infertility
- ❒ History of miscarriage or spontaneous abortion
- ❒ Menstrual problems – PMS
- ❒ **Thyroid disease**
- ❒ Diagnosis of hyperprolactinemia
- ❒ **Diagnosis of Diabetes (type I or type II)**
- ❒ Hypoglycemia
- ❒ PCOS (polycystic ovary disease)
- ❒ Endometriosis
- ❒ Chronic urinary tract infections
- ❒ Chronic respiratory infections
- ❒ **Asthma**
- ❒ Vaginal, oral, or nail bed yeast infections
- ❒ Fever blisters or mouth ulcers
- ❒ Skin rash
- ❒ Eczema
- ❒ Psoriasis
- ❒ **Dermatitis Herpetiformis**
- ❒ **Vitiligo**
- ❒ Gall bladder problems
- ❒ Elevated liver enzymes
- ❒ Non-alcoholic fatty liver
- ❒ **Autoimmune hepatitis**
- ❒ **Lymphoma**
- ❒ Platelet disorders