Medical & Health History

Date: _____ Name: _____ Birthdate: _____ (S)ingle (M)arried (D)ivorced (W)idow (M)inor: _____

Street: _____ City: _____ State: _____ Zip: _____

Day Phone: _____ Night Phone: _____ Spouse/Parent Name: _____

If you could wave a magic wand, what is the one health complaint you'd fix? _____

Please rate any condition that applies to you NOW and in the PAST, using the following scale:

5 = Severe 4 = Strong 3 = Moderate 2 = Mild 1 = Weak 0 = Not Present

- Start by going through and marking in the NOW column only the conditions that apply to you currently
- Then go back and respond in the PAST column to the ones you marked in the NOW column

4th Test	3rd Test	2nd Test	NOW	PAST	CONDITION	4th Test	3rd Test	2nd Test	NOW	PAST	CONDITION
					Acne						Crohn's Disease
					ADD / ADHD						Cystic Fibrosis
					Adrenal Hyper-function						Cystitis (interstitial)
					Adrenal Hypo-function						Cytomegalovirus (CMV)
					AIDS						Degenerative Joint Disease
					Alcoholism						Depression
					Alzheimer's Disease						Dermatitis
					Amenorrhea						Diabetes (type I)
					Anemia						Diabetes (type II)
					Angina Pectoris						Diarrhea
					Anxiety						Diverticulitis
					Appetite (excess)						Diverticulosis
					Appetite (reduced)						Dry Skin
					Arrhythmia						Duodenal Ulcer
					Arteriosclerosis						Dysmenorrhea
					Arthritis (osteo)						Dyspepsia (indigestion)
					Arthritis (rheumatoid)						Ear Infections
					Asthma						Eczema
					Atherosclerosis						Edema (fluid retention)
					Autism						Emphysema
					Bacterial Infection						Endometriosis
					Bad Breath (halitosis)						Epilepsy
					Bell's Palsy						Epstein Barr Virus (EBV)
					Benign Prostatic Hyperplasia						Feet Burning
					Biliary Insufficiency						Female Frigidity
					Biliary Stasis						Female Infertility
					Bipolar Disorder						Fibrocystic Breast Disease
					Bleeding Gums						Fibroids (uterine)
					Body Odor						Fibromyalgia
					Bone Spurs						Flatulence (gas)
					Bradycardia						Flu (influenza)
					Bronchitis						Fractures
					Bruxism (grinding teeth)						Fungal Infections
					Burns (1st, 2nd, 3rd degree)						Gall Bladder Dysfunction
					Bursitis						Gall Stones
					Cancer						Gastric Ulcer
					Canker Sores						Genital-Urinary Infection
					Carbohydrate Sensitivity						GERD
					Cataracts						Glaucoma
					Cavities (dental caries)						Goiter
					Celiac Disease (sprue)						Gout
					Cervical Dysplasia						Gum Bleeding or Recession
					Chicken Pox						Headaches
					Cholesterol Low (HDL)						Heel Spurs
					Cholesterol Low (total)						Heavy Metal Toxicity
					Cholesterol High (LDL)						Hemochromatosis
					Cholesterol High (total)						Hemorrhoids
					Chronic Fatigue Syndrome						Hepatitis
					Circulation Reduced						Hiatal Hernia
					Cirrhosis						High Blood Pressure
					Cold Feet						High Blood Sugar
					Cold Hands						High Triglycerides
					Cold Sores (HSV-1)						Hives (uticaria)
					Colitis (mucous)						Homocystinuria
					Colitis (ulcerative)						Hot Flashes
					Common Cold						Hyperactivity
					Congestive Heart Failure						Hyperthyroid
					Constipation						Hypochlorhydria
					Coronary Artery Disease						Hypoglycemia
					Cramps, Menstrual						Hypothyroid
					Cramps, Muscle						Ileitis

4th Test	3rd Test	2nd Test	NOW	PAST	CONDITION
					Immune Depression
					Impotency
					Incontinence
					Infection (bacterial)
					Infection (ear)
					Infection (parasitic)
					Infection (prostate)
					Infection (respiratory)
					Infection (sinus)
					Infection (urinary)
					Infection (viral)
					Infection (yeast or fungal)
					Infertility
					Inflammation (general)
					Inflammation (vascular)
					Influenza
					Insomnia
					Irritability
					Joint Pain
					Kidney Stones
					Lactose Intolerance
					Leukemia
					Lymphoma
					Liver Disease or Problems
					Low Blood Pressure
					Lung Problems
					Lupus
					Lyme Disease
					Macular Degeneration
					Manic Depressive Disorder
					Measles
					Melanoma
					Meniere's Disease
					Menorrhagia
					Mercury Toxicity
					Migraine Headache
					Mitral Valve Prolapse
					Mononucleosis
					Multiple Sclerosis
					Mumps
					Muscular Dystrophy
					Myasthenia Gravis
					Nausea
					Nausea (during pregnancy)

4th Test	3rd Test	2nd Test	NOW	PAST	CONDITION
					Nervousness
					Night Blindness
					Osteoporosis
					Pancreatitis
					Parasthesia
					Parkinson's Disease
					Peptic Ulcer
					Periodontal Disease
					Phobias
					PMS
					Pneumonia
					Polycythemia
					Pregnancy
					Psoriasis
					Purpura Simplex
					Pyloric Valve Dysfunction
					Radiation Therapy
					Reynaud's Disease
					Ringworm
					Schizophrenia
					Sciatica
					Scleroderma
					Seborrhea
					Seizures
					Sex Drive Diminished
					Shingles (herpes zoster)
					Skin Rashes
					Stroke
					Sunburn
					Surgery
					Syndrome-X
					Tachycardia
					Tendonitis
					Thrombophlebitis
					Thrush (oral yeast/fungus)
					Tic Douloureux
					Tinnitus (ringing in ear)
					Tuberculosis (TB)
					Upset Stomach (indigestion)
					Varicose Veins
					Vertigo
					Vitiligo
					Wilson's Disease

YES (x)	QUESTION
	Are you currently under a physician's care?
	Have you had a serious operation?
	Have you had a serious illness?
	Are you allergic to any medications?
	Do you have a pacemaker or artificial heart valve implant?
	Have you had surgery, radiation or chemo for cancer or other issue?
	Do you smoke tobacco?
	Do you drink beer and/or wine?
	Do you drink hard liquor?
	Are you currently pregnant?
	Do you have Hormone Sensitive Cancer?
	Are you currently taking mood elevators/anti-depressants?
	Are you currently taking thyroid hormone?
	Are you taking other hormones?
	Do you use "recreational drugs?"
	Is your energy good all day long?
	Have you traveled outside the U.S.?
	Do you have pets?
	Do you have root canals?
	Do you have metal fillings?
	Have you had teeth extracted?
	Do you wear braces or a dental splint?
	Do you have TMJ (jaw), spine or neck pains?
	Have you had any head, neck or back injuries?
	Have you been exposed to chemical toxins?

	Do you have trouble falling asleep?
	Do you have trouble staying asleep?
	Do you awaken between 2-3 a.m.?
	Do you need to eat in order to fall back asleep?
	Is your mind racing then?
	Do you feel rested and refreshed when you get up in the morning?
	Do you recall your dreams?
	Do you often have nightmares?
	Do you use sleeping pills to get to sleep?
	Do you use melatonin to sleep?

What time do you normally go to bed?
What time do you get up in the morning?
When is your energy best during the day?
When is your energy worst during the day?
How long have you been exceptionally stressed (if you have been)?
How long has it been since you felt your best?
If you have chronic pain, explain:
What is your heritage (German, English, Mexican, etc.)?
List prescription medications you are taking now:
List over-the-counter drugs you take: