Avera
Integrative Medicine

Patient _____

Date of Birth _____ Date: _____

HEALTH HISTORY

Briefly describe our main concern you would like to address with the doctor.

_____

_____

_____

_____

_____

Secondary Concerns:

List briefly below other physical or mental symptoms that are troubling you now.

_____

_____

_____

_____

_____

_____

C. Past Medical History

1. Please list all prescription medications or nutritional supplements you are now taking:

Name of Medicine or supplements	Dosage (how much and how many times/day)	Reason for taking them	Name of doctor prescribing

2. Hospitalizations:

Approximate Dates	Reason

3. Operations:

Approximate Date	Type of operation	Reason for operation	Complications

4. Serious illnesses not listed on previous page:

Name of illness	Date illness started	Full Recovery? (check if yes, or explain if no)

5. Allergies: Please itemize your allergies.

Substances (medication, food, plants, etc)	What kind of allergic reactions

Personal History:

Place of birth: _____ Education _____ Occupation: _____

Marital Status: Single _____ Married _____ Other _____

Residential status: Live alone _____ With a friend _____ With family _____

Do you have adequate support at home? Yes _____ No _____

Dietary Habits:

Eating out at restaurants: 0-1 time/week___ 1-2 times/week____ 3-4 times/week ____

More than 4 times/week ____

Use of alcoholic beverages: None____ 0-2/day ____ >2/day ____ 0-4/weekly ____ 0-4 monthly ____

Food preferences: (check as many items as appropriate)

Hot spicy food ____ Red meat ____ Vegetables ___ Fruits ____ Dairy products ____ Sweets ____

Chocolate ____ Fast food___ Frequent snacks ____

Daily beverage:

Coffee (cups/day) ____ Tea (cups/day) ____ Sodas (glasses/day)____ Bottled water (glasses/day)____

Tap water (glasses/day)____

Exercise: Type _____Frequency _____

Sleep:

1. Usual bed time _____
2. Usual wake time _____
3. Any daytime naps _____
4. Difficult to fall asleep _____
5. Any sleep aides _____
6. Waking up in the middle of the night _____
7. Can't fall back asleep after waking _____ how many times or the average _____
8. Restless sleep _____
9. Frequent and vivid dreaming _____
10. Nightmares _____
11. Snoring _____
12. Talk in your sleep _____
13. Sleep apnea _____
14. CPAP _____

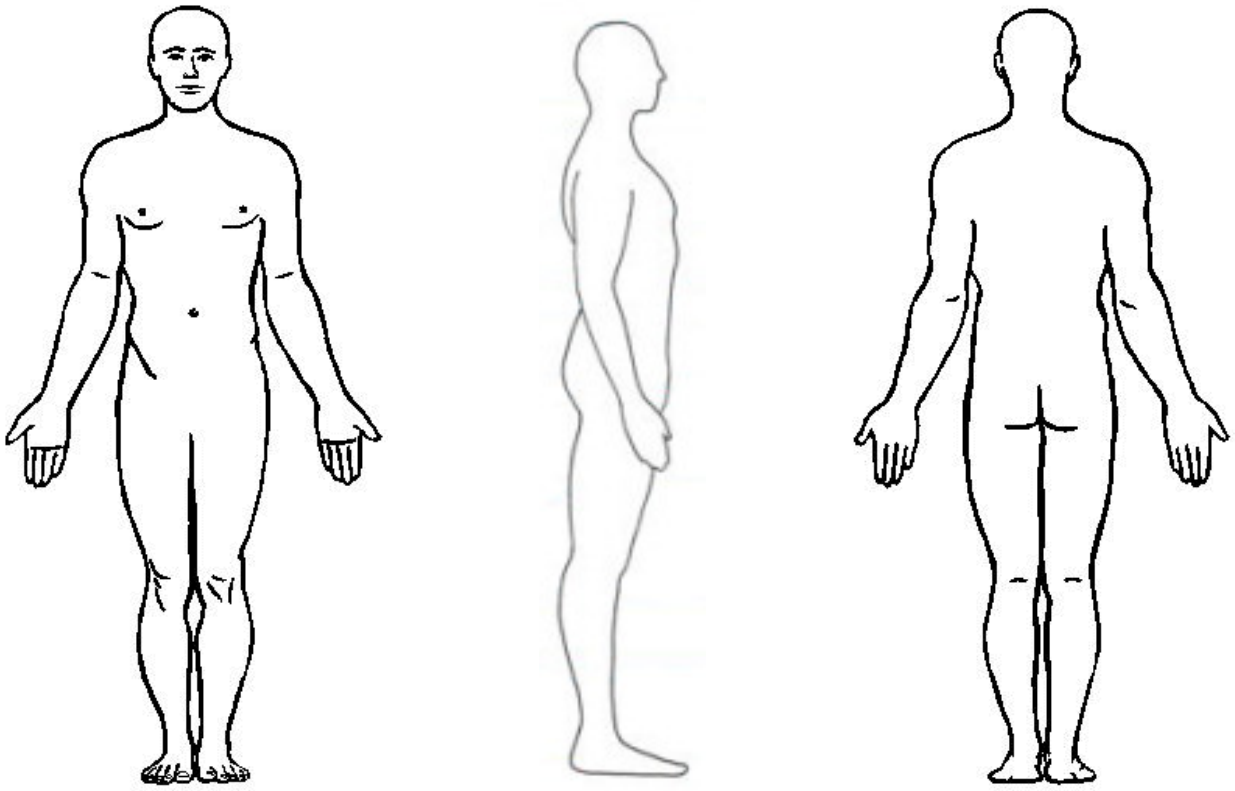
Do you have any of the following symptoms at present or recently?

(Check 1 or more symptoms if appropriate)

1. Pain _____ 2. Numbness _____ 3. Itching _____ 4. Redness _____ 5. Swelling ____

6. Burning Sensation _____ 7. Coldness _____ 8. Other (specify) _____

If you check off any items above, indicate area(s) affected by the symptoms in the drawing below. For example, if you have headaches, you should check #1, then draw a circle on the part of the head affected by the headaches and write the number 1 in it. Likewise, if you have itching on you back, draw a line around the itching area and write 3 in it.



REVIEW OF BODY SYSTEMS

GENERAL: My health is: Excellent ____ Good ____ Fair ____ Poor ____
My energy level is: Normal ____ Decreased ____ Increased ____ Variable ____
I experience: Fatigue ____ Fevers ____ Sweats ____ Chills ____ Poor appetite ____
My weight is: Now _____ One year ago _____ 5 years ago _____ Best weight _____

SKIN: Rashes ____ Bruising ____ Other _____

EYES: Any problems: _____

EARS: Any problems: _____

NOSE, THROAT AND SINUSES: Nose blowing ____ Sneezing ____ Sinus ____ Post-nasal drip ____
Sinus infections ____ Frequent colds ____ Loss of smell ____ Sore throat ____ Hoarseness ____
Throat clearing ____ Tickle in throat ____
Other problems: _____

HEART
Chest pressure/Pain _____ If yes, describe _____
Have you been given: Nitroglycerin _____ Heart pills _____ Describe _____
Do you get: Ankle swelling _____ Irregular heartbeat _____
Does shortness of breath awaken you from sleep?_____ If yes, describe _____
Other problems_____

STOMACH AND DIGESTION:
Do you get: Frequent heartburn _____ Frequent upset stomach _____
Gas _____ Acid taste in mouth _____
Do you have difficulty swallowing _____ Describe: _____
Does food come back up or stick _____ If yes, explain _____
Do you have frequent: Nausea _____ Vomiting _____ Abdominal pain _____ Diarrhea _____ Constipation _____
Have you had recent changes in shape or frequency of stools _____
Feel need to have bowel movement but can't? Yes_____ No_____
Stool pattern: Daily _____ Every other day _____ Every 3 days _____ Other _____
If >1 stool/day how many? _____
Stool Appearance: Formed _____ Soft and flaky _____ Pasty _____ Watery _____ Hard and pellet like _____
Blood in stool_____ Mucus in stool _____
Stool color: Black _____ Dark brown _____ Brown _____ Light color _____
Other: _____

GENITO-URINARY SYSTEM:

Difficulty with frequent urination _____ Painful urination _____ Dribbling _____

Blood in urine _____ Urine or kidney infections _____

Urine color: Dark _____ Light yellow _____ Pale (colorless) _____

How many times do you awaken at night to urinate _____

FOR MEN:

Difficulty with: Erections _____ Ejaculation _____ Orgasm _____ Libido _____

Slowing of urinary stream _____

Other problems _____

FOR WOMEN:

Date of last period _____

Difficulty with painful intercourse _____ Orgasm _____ Libido _____

Other problems_____

MENSTRUATION:

Your period occurs every _____

Appearance of the menstrual flow is: Bright red _____ Dark red _____

Are there clots Yes _____ No _____

Cramps associated with periods Yes_____ No _____

If yes, cramps occur: Before period starts _____ As period starts _____ Throughout period _____

Vaginal discharge Yes _____ No _____

If yes, color is: White _____ Yellow _____ Brownish _____ Bloody ____

It has: Strong odor _____ No odor_____

Do you have mood changes relating to your menstrual cycle? If yes, please describe briefly.

_____

_____

NEUROLOGICAL SYSTEM:

Do you have weakness of: Arms _____ Legs _____ General _____

Do you get: Dizzy _____ Wobbly _____ Room spinning _____ Have you fallen _____

Do you get headaches _____ If yes, describe _____

Other problems _____

ENDOCRINE SYSTEM:

Have you ever been given a diet for Weight loss _____ Diabetes _____ Weight gain _____ Other reasons _____

If yes, explain _____

Have you ever been on thyroid medication: Recently _____ Long time ago _____ Never _____

Have you noticed changes in your: Skin ____ Hair (not color) _____ Heat tolerance _____ Cold tolerance ____

Appetite _____ If yes, explain _____

Do you feel: Thirsty often and need to drink a lot of fluid _____ Thirsty but stop after a couple of sips _____

Strong preference for drinking: Hot _____ or Cold _____ beverages.

MUSCULO-SKELETAL SYSTEM:

Do you get: Joint swelling _____ Redness _____ Warmth _____ Tenderness _____

Do your fingers turn: White _____ or Blue _____ in the cold

Other problems: _____

PSYCHIATRIC:

Are you: Nervous _____ Worried _____ Depressed _____ Anxious _____ Sad _____

If yes, explain _____

Other problems: _____

MISCELLANEOUS: Is there anything else you would like me to know about your health or what you want to get out of this visit? _____

HISTORY OF STRESSORS

Mark below the events or cluster of events that have been the most traumatic for you and select the emotion that predominated during these stressful situations. For instance, you have witnessed a close friend killed by a drunk driver. The overwhelming emotion may be sorrow and anger.

Date	Stressful Event	Emotion

Live better. Live balanced. Avera.