# Health History Form

Name: _____Date of Birth: _____

What is your intention for this appointment? Please include any symptoms you are experiencing, when they started, and any associations you have made between your symptoms and other things in your life. What outcome would you like to work toward? _____

_____

_____

**General Health and Habits**

How would you rate your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Dietary preferences/restrictions: _____ Any cravings? _____

Typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

Snacks and drinks: _____

Do you routinely exercise? Yes ☐ No ☐ Type of exercise: _____

Do you smoke? _____ How much? _____ For how long? _____

If not now, have you previously smoked? _____ When did you quit? _____

Do you drink alcohol? ____ How much? _____ How often? _____ Quit? _____

Do you drink caffeine (coffee, tea, soda)? ____ How much? _____

What is your usual bedtime? ____ When do you usually wake? _____Is your sleep restful? ____

What medications do you take? _____

_____

What supplements do you take? _____

_____

Do you use mood altering drugs (marijuana, cocaine, etc.)? _____ How often? _____

What do you use them for (relaxation, mood elevation, etc.)? _____

**Medical History**

Please check if you or a member of your immediate family (parents, grandparents, siblings, aunts, uncles, children) have, or have had, any of the following medical conditions? If yes, please describe below.

| Condition | Self | Family | Condition | Self | Family |
|---|---|---|---|---|---|
| Headaches/ Migraines | | | Thyroid Disease | | |
| Seizures | | | Diabetes | | |
| Heart Disease | | | Breast Disease | | |
| High Blood Pressure | | | Blood Disease | | |
| Blood Clots | | | Skin Disease | | |
| Respiratory Problems | | | Chronic Fatigue | | |
| Jaundice/Hepatitis (Liver Disease) | | | Psychiatric/ Mental Health Problems | | |
| Gallbladder disease | | | Osteoporosis | | |
| Peptic/stomach Ulcer/ GERD | | | Arthritis | | |
| Kidney Disease | | | Female Problems | | |
| Frequent Bladder Infections | | | Alcoholism | | |
| Bowel/Colon Disease | | | Drug Addiction | | |
| Cancer | | | Eating Disorders | | |

Is there anything else about your health you feel I should know to care for you better? _____

_____

**Hospitalizations/ Surgeries**

| Date(s) | Diagnosis and/or Surgery |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Allergies**

Drug or medication allergies:_____

_____

Food, environmental, latex, etc. allergies: _____

_____

**Pregnancy History (please include miscarriages and abortions)**

| Date | Full Term? | Type of Delivery | Male/Female | Complications |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Gynecological History**

Age at first period: _____ Date last period began: _____

Do you get any premenstrual symptoms? If so, at what point during your cycle do they begin?

_____

Do you have any menstrual concerns? _____

_____

When was your last Pap Smear? _____ Was it normal? _____

Have you ever had an abnormal Pap Smear? ____ When? _____Treatment? _____

Are you sexually active? _____Are your partners male, female, or both? _____

Do you experience any discomfort with sexual activity? _____

Do you practice safe sex? ____ Current method of contraception? _____

How long have you used this method? _____ Any problems with it? _____

Past birth control methods used: _____

Have you had a new partner within the last 6 months? _____

Have you had more than one partner within the last 6 months? _____

Do you feel you may be at risk for a sexually transmitted infection/disease (STI/STD)? _____

Have you ever had an HIV test? _____ When? _____ Result? _____

Any history of sexual abuse? _____

Any sexual concerns to discuss? _____

**Previous Exams and Reports**

Last full Physical Exam: _____ With Who? _____

Last full GYN Exam: _____ With Who? _____

Last Mammogram/Thermogram: _____ Result? _____

Last Bone Mineral Density: _____ Result? _____

Last Colonoscopy: _____ Result? _____

**Life Stresses**

How would you rate your stress (0 being no stress, 10 being extremely stressed)? _____
Please answer yes or no if the following stressors apply to you. If yes, please add a comment:

| **Stressor** | **Yes/ No** | **Comment** |
|---|---|---|
| My Health | | |
| My Weight | | |
| My Alcohol, Drug, or Cigarette Use | | |
| My Mental Health | | |
| Growing Older | | |
| Sexual Problems | | |
| My Friendships | | |
| My Finances | | |
| My Safety | | |
| My Relationship with my Partner | | |

| | | |
|---|---|---|
| My Relationship with another Family Member | | |
| A Family Member's Health | | |
| A Family Member's Alcohol, Drug, or Cigarette Use | | |
| A Family Member's Mental Health | | |
| A Family Member's Safety | | |
| My Job (new job, losing a job, relationships at work, unsatisfying work, or work environment) | | |
| Other? | | |

What do you do to reduce stress in your life? _____

_____

What topics are your top 3 priorities to address in our initial visit?

1. _____
2. _____
3. _____

**NOTE**: If filling out this form brought up many topics you would like to discuss, please feel free to schedule an 80-minute initial visit OR multiple sessions to ensure we have enough time to address all of your concerns. Thank you for taking time to evaluate your health.