Patient Health History

Name: ____ **Date:** ____/____/______

Please check if you have had in the past three months:

General

[ ] Anemia
[ ] Fatigue
[ ] Fever
[ ] Weight Loss
[ ] Sweats
[ ] Chills
[ ] Drug Addiction
[ ] Poor Appetite
[ ] Localized Weakness
[ ] Bleed or Bruise Easily
[ ] Peculiar Tastes or Smells
[ ] Strong Thirst (hot or cold drinks)
[ ] Sudden Energy Drop
[ ] Poor Sleep Habits
[ ] Tremors
[ ] Poor Balance
[ ] Cravings
[ ] Weight Gain
[ ] Alcoholism
[ ] Tetanus Shot
[ ] Frequent cold/flu

Skin and Hair

[ ] Rashes
[ ] Itching
[ ] Dandruff
[ ] Change in hair/skin texture
[ ] Ulcerations
[ ] Eczema
[ ] Open sore
[ ] Acne
[ ] Corns
[ ] Warts
[ ] Psoriasis
[ ] Recent moles
[ ] Loss of Hair
[ ] Hives
[ ] Nail Problems
[ ] Dry skin

Head, Eyes, Ears, Nose and Throat

[ ] Dizziness/Vertigo
[ ] Poor Vision
[ ] Cataracts
[ ] Ringing in ears
[ ] Sinus Problems
[ ] Grinding Teeth
[ ] Nasal Congestion
[ ] Headaches
[ ] Concussions
[ ] Eye Strain
[ ] Night Blindness
[ ] Blurry Vision
[ ] Poor Hearing
[ ] Nose Bleeds
[ ] Hoarseness
[ ] Migraines
[ ] Eye Pain
[ ] Color Blindness
[ ] Earaches
[ ] Spots in front of eyes
[ ] Recurrent Sore Throats
[ ] Facial Pain

Cardiovascular

[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Palpitations
[ ] Irregular Heartbeat
[ ] Mitral Stenosis
[ ] Mitral Prolapse
[ ] Myocarditis
[ ] Pneumatic Heart Disease
[ ] Chest Pain
[ ] Varicose Veins
[ ] Swelling of Hands/Feet
[ ] Fainting
[ ] Coronary Heart Disease
[ ] Difficulty in Breathing
[ ] Hardening of Arteries
[ ] Phlebitis
[ ] Blood Clots
[ ] Cold hands/feet

Respiratory

[ ] Cough
[ ] Bronchitis
[ ] Difficulty breathing lying down
[ ] Emphysema
[ ] Coughing Blood
[ ] Pneumonia
[ ] Asthma
[ ] Pain w/ deep breath
[ ] Production of Phlegm
[ ] Pleurisy

Gastrointestinal

[ ] Nausea
[ ] Vomiting
[ ] Bad Breath
[ ] Abdominal Pain or Cramps
[ ] Indigestion
[ ] Ulcer
[ ] Constipation
[ ] Gas
[ ] Blood in Stools
[ ] Rectal Pain
[ ] Chronic Laxative Use
[ ] Colitis
[ ] Diarrhea
[ ] Belching
[ ] Black Stools
[ ] Hemorrhoids
[ ] Acid Reflux

Genitourinary

[ ] Bed Wetting
[ ] Kidney Infections / Stones
[ ] Genital Herpes
[ ] Cystitis
[ ] Blood in Urine
[ ] Painful Urination
[ ] Venereal Disease
[ ] Incontinence
[ ] Frequent Urination
[ ] Bladder Infections
[ ] Prostate Problems

NATURAL HEALTH CHOICE

Pregnancy and Gynecology

[ ] Number of Pregnancies
[ ] Number of Abortions
[ ] Number of Births
[ ] Number of Miscarriages
[ ] Use of Birth Control
[ ] Clots
[ ] Hot Flash/Night Sweats
[ ] Osteoporosis
[ ] Age at 1st Menstruation
_____ Time between Menstruation
_____ Duration of Menstruation
_____ First Date of Last Menstruation
[ ] Irregular Periods
[ ] Endometriosis
[ ] Frequent changes in emotion
[ ] Unusual Character (heavy/light)
[ ] Vaginal Sores
[ ] Vaginal Discharge
[ ] Breast Lumps
[ ] Painful Periods/Cramps
[ ] Uterine Fibroids

Musculoskeletal

[ ] Neck Pain
[ ] Back Pain
[ ] Hand/Wrist Pain
[ ] Muscle Pains
[ ] Muscle Weakness
[ ] Shoulder Pain
[ ] Knee Pain
[ ] Foot/Ankle Pain
[ ] Hip Pain

Neuropsychological

[ ] Seizures
[ ] Areas of Numbness
[ ] Concussion
[ ] Bad Temper
[ ] Difficulty Concentrating
[ ] Dizziness
[ ] Lack of Coordination
[ ] Depression
[ ] Easily susceptible to stress
[ ] Loss of Balance
[ ] Poor Memory
[ ] Anxiety
[ ] ADD

Infection

[ ] Measles
[ ] Rheumatic Fever
[ ] Malaria
[ ] Small Pox
[ ] Mumps
[ ] Tuberculosis
[ ] Chicken Pox
[ ] Whopping Cough
[ ] Typhoid Fever
[ ] Scarlet Fever

Are you allergic to any of the following?

( ) Medicine
( ) Food
( ) Herbs
( ) Others

Do you have or are you any of the following?

( ) Pacemaker
( ) Electric Implants
( ) Metal Implants
( ) Severe Bleeding Disorders
( ) Pregnant
( ) HIV Positive
( ) Hepatitis A/B/C

Do you consume:

Coffee: [ ] moderate [ ] medium [ ] heavy
Alcohol: [ ] moderate [ ] medium [ ] heavy
Tea: [ ] moderate [ ] medium [ ] heavy
Tobacco: [ ] moderate [ ] medium [ ] heavy

Family History (please include the relation)

[ ] Migraines ____________________
[ ] Heart Disease ____________________
[ ] Allergies ____________________
[ ] Asthma ____________________
[ ] Arthritis ____________________
[ ] Diabetes ____________________
[ ] Glaucoma ____________________
[ ] Stroke ____________________
[ ] High Blood Press ____________________
[ ] Mental Illness ____________________
[ ] Gall Stones ____________________
[ ] Cancer ____________________
[ ] Thyroid Disease ____________________
[ ] Epilepsy ____________________

Signature ____ **Date** ________________________

NATURALHEALTHCHOICE