Health History Form

Date: _____
Dr. Maleigha Watts

Name: _____ DOB: _____

List your health concerns in order of importance (from most to least):

1) _____
2) _____
3) _____
4) _____
5) _____

Name and telephone number of Primary Care physician:

_____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:						
Age when died:						
Reason for death:						
Cancer type:						
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

1) _____
2) _____
3) _____

4) _____
5) _____

When was your last blood work performed? _____(date)

Please Note When & Why You Have Had Each of the Following:

X-Rays: _____
MRI/Cat Scans: _____
Ultrasounds: _____
Accidents: _____
TB Test: _____
HCV: _____
HIV: _____
Last Dental Visit: _____
Last Eye Exam: _____

Did you have the following Disease (D), Get Immunized (I), or Neither (N):

Measles:	D I N	Chicken Pox:	D I N	Hemophilus (Hib):	D I N
Rubella:	D I N	Tetanus:	D I N	Whooping Cough:	D I N
Mumps:	D I N	Hepatitis B:	D I N		

Any vaccination reactions: _____

List Yes (Y), No (N) or Past (P) regarding use of the following:

Antacids:	Y N P	Steroids:	Y N P
Smoking:	Y N P	Packs per day & number of years:	_____
Analgesics:	Y N P	Laxatives:	Y N P
Coffee:	Y N P	Cups per day if Yes/Past:	_____
Soda Pop:	Y N P	Ounces per day if Yes/Past:	_____
Alcohol:	Y N P	How often & how much if Yes/Past:	_____
Any Alcohol Addiction:	Y N P	Any Alcohol Treatment:	Y N P
Recreational Drugs:	Y N P	Any Drug Addictions:	Y N P
Any Drug Treatment:	Y N P		

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and including dosage:

_____

_____

_____

Present Weight: _____ Weight one year ago: _____

Height: _____

Maximum weight and when: _____

Minimum weight as adult & when: _____

Ideal Weight: _____

REGARDING THE NEXT LONG SECTION: Please circle (Y) if you have the problem NOW, (N) if you've NEVER had the problem, (P) if you had the problem in the PAST.

Good Energy: Y N P

Fatigue: Y N P

If you have fatigue, when in morning, afternoon, evening is it the worst? _____

If you have fatigue, can you do what you need to during the day? Y N

GENERAL				
Hot:	Y N P		Weight loss or gain	Y N P
Cold:	Y N P		Fatigue	Y N P
Chills or Fever:	Y N P		Difficulty sleeping	Y N P
Sweats or night sweats:	Y N P		Heat or cold interolance:	Y N P
SKIN				
Rash:	Y N P		Color Change:	Y N P
Hives:	Y N P		Lump:	Y N P
Psoriasis/eczema:	Y N P		Itchy:	Y N P
Dry:	Y N P		Warts/moles:	Y N P
Cancer:	Y N P		Perspiration:	Y N P
HEAD				
Headache:	Y N P		Migraine:	Y N P
Dandruff:	Y N P		Head Injury:	Y N P
Oil/dry hair:	Y N P		Hair loss:	Y N P
NOSE				
Sinusitis:	Y N P		Nosebleeds:	Y N P
Congestion:	Y N P		Runny nose or post nasal drip	Y N P
History of polyps:	Y N P		Decreased smell:	Y N P
EARS/EYES				
Dry/Watery:	Y N P		Blurry Vision:	Y N P
Double Vision	Y N P		Cataracts:	Y N P
Glaucoma:	Y N P		Styes:	Y N P
Strain:	Y N P		Discharge:	Y N P
Itchy:	Y N P		Dark under Eyelid:	Y N P
Change in hearing:	Y N P		Tinnitus	Y N P
Recurrent ear infections	Y N P		Ear pain:	Y N P

MOUTH/THROAT				
Canker sores:	Y N P		Cold sores:	Y N P
Sore Throat:	Y N P		Gum disease or cavities:	Y N P
Dentures:	Y N P		Cavities:	Y N P
Loss of taste:	Y N P		Hoarseness:	Y N P
NECK				
Stiffness:	Y N P		Swollen Glands:	Y N P
Full movement:	Y N P		Tension:	Y N P
RESPIRATORY				
Cough:	Y N P		Shortness of breath:	Y N P
Blood in sputum:	Y N P		History of bronchitis:	Y N P
Wheezing:	Y N P		History of pneumonia:	Y N P
Painful breathing:	Y N P		History of tuberculosis:	Y N P
CARDIOVASCULAR				
High blood pressure:	Y N P		Low blood pressure:	Y N P
Arrthymias:	Y N P		Palpitations:	Y N P
Edema:	Y N P		Dizziness:	Y N P
Murmurs:	Y N P		Chest pain:	Y N P
URINARY TRACT				
Incontinence:	Y N P		Pain with urination:	Y N P
Frequent infections:	Y N P		Kidney stones:	Y N P
Increased or decreased urgency:	Y N P		Discharge or blood:	Y N P
GASTROINTESTINAL				
Heartburn:	Y N P		Bowel movement: Frequency:	
Indigestion:	Y N P		Recent bowel movement change:	Y N P
Bloating:	Y N P		Diarrhea or constipation:	Y N P
Nausea:	Y N P		Vomiting:	Y N P
Hemorrhoids:	Y N P		Gall bladder disease:	Y N P
Change in appetite:	Y N P		Liver disease:	Y N P
Pancreatitis:	Y N P		Ulcer:	Y N P
MALE GENITALIA				
Testicular pain or swelling:	Y N P		Sexually active:	Y N P
Hernia:	Y N P		S.T.I.:	Y N P
Discharge:	Y N P		Prostate Disease/Symptoms:	Y N P
Impotency:	Y N P		Sexual Orientation:	
FEMALE GENITALIA				
Age period began:			How often period occurs:	
How long period lasts:			Heavy menstrual	Y N P

			bleeding:	
Premenstrual cramping:	Y N P		Menstrual pain:	Y N P
PMS:	Y N P		Food cravings:	Y N P
Times pregnant:			How many births:	
Miscarriages:			Abortions:	
Last pap smear:			Sexual orientation:	
Any abnormal paps:	Y N P		When was abnormal pap:	
Menopausal since what age:			Use of hormones:	Y N P
Types of hormones used:			Health libido:	Y N P
Dry vagina:	Y N P		Sexually active:	Y N P
Pain with intercourse:	Y N P		Vaginitis:	Y N P
S.T.I.:	Y N P		Mammography:	Y N P
Bone Density Test:	Y N P		If yes what were results:	

Please list any birth control used and ages used: _____

_____

MUSCULOSKELETAL AND NERVOUS				
Weakness:	Y N P		Joint pain:	Y N P
Stiffness:	Y N P		Leg cramps:	Y N P
Tremors:	Y N P		Paralysis:	Y N P
Numbness/tingling:	Y N P		Sciatica:	Y N P
History of Carpal Tunnel Syndrome:	Y N P		Seizures:	Y N P
Fainting:	Y N P			
MENTAL AND EMOTIONAL				
Depression:	Y N P		Anger/irritability:	Y N P
Suicidal:	Y N P		High strung/tense:	Y N P
Anxiety:	Y N P		Fear/panic:	Y N P
Eating disorder:	Y N P		Psych hospitalization:	Y N P

Exercise

How often do you exercise? _____

What type of exercise? _____

For how long? _____

Hobbies: _____

Sleep

How long per night? _____

If you wake up frequently, what is the reason? _____

Nightmares:	Y N P	Wake Refreshed:	Y N P
Must nap during the day:	Y N P	Sleep walk:	Y N P
Grind teeth:	Y N P	Snore:	Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

_____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

_____

_____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

_____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

_____

Do you use pesticides, herbicides or other chemicals around your home? _____

_____

Social Life

Enjoy job: Y N P Hours worked per week: _____

Highest Level of Education: _____

Active spiritual practice: Y N P

Quality of significant relationship: _____

_____

History of sexual, mental/emotional, physical abuse: Y N P

What is your greatest health concern: _____

_____

How does it limit you the most: _____

_____

How committed are you towards making valuable changes: Little Moderately Very

Allergies

List all known Allergies (food, drugs, environment): _____

_____

_____

_____

Additional Information

Please list any additional information/topics which you believe is important we address during your office visit:

_____

_____

_____

_____

_____

_____