



Patient Health History
Functional Medicine patients

**PLEASE RETURN THIS FORM
ONE WEEK PRIOR TO YOUR
INITIAL APPOINTMENT!**

Name _____

Date _____

Date of Birth _____ Age _____ Height _____

Weight _____

Race/Ethnicity: Caucasian African American Asian Hispanic Native American Other

List your major health concerns along with the cause(s) and what improves or aggravates them (if known or suspected). Also include prior treatments:

1.

2.

3.

4.

Are your health concerns interfering with (check all that apply):

Work Daily Routine Sleep Other _____

If your condition involves discomfort mark the table below with an 'X' in the appropriate box to indicate location, type and severity (using a scale of 1 to 10 with 10 being the most painful).

	Pain: ache	Pain: sharp	Pain: radiating	Pain: constant	Pain: intermittent	Tight- ness	Numb- ness	Severity (1-10)
Head								
Neck								
Upper back								
L shoulder								
R shoulder								
Mid back								
Low back								
Abdomen								
L hip								
R hip								
L knee								
R knee								
L ankle								
R ankle								
L foot								
R foot								
Other								

Comments: _____

Please list other practitioners seen for these concerns: (or check here for none:)

	Name	Date (approx.)	Testing/Treatment
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Additional remarks about previous treatment:

Current primary care physician _____

Health Maintenance Update

Please indicate approximate dates and results of last:

Physical exam _____

Dental exam _____

Blood tests _____

Eye exam _____

Other _____

List all medications you are currently using, or have used recently. Include all over-the-counter medications. List dosages and approximate length of time you have used each medication:

List (include name, brand, dosage) all vitamins, minerals, herbs, and other natural products you are currently using:

List medication/supplement/environmental allergies or intolerances and associated reactions:

List past or present exposure to harmful chemicals:

Do you live/work in a damp or moldy home/office? _____

Do you have pets? _____

Illness / Conditions History

Please mark the appropriate box with an 'X' if these symptoms occur presently or have occurred in the past 6 months. Leave blank any spaces that do not apply.

GASTROINTESTINAL	Yes	Past
Irritable bowel syndrome		
GERD (reflux)		
Crohn's disease/ulcerative colitis		
Peptic ulcer disease		
Celiac disease		
Gallstones		
Other: _____		
RESPIRATORY		
Bronchitis		
Asthma		
Emphysema		
Pneumonia		
Sinusitis		
Sleep apnea		
Other: _____		
URINARY/GENITAL		
Kidney stones		
Gout		
Interstitial cystitis		
Frequent yeast infections		
Frequent urinary tract infections		
Sexual dysfunction		
Sexually transmitted diseases		
Other: _____		
ENDOCRINE/METABOLIC		
Diabetes		
Hypothyroidism (low thyroid)		
Hyperthyroidism (overactive thyr.)		
Polycystic Ovarian Syndrome		
Infertility		
Metabolic syndrome/insulin resist.		
Eating disorder		
Hypoglycemia		
Other: _____		
INFLAMMATORY/IMMUNE		
Rheumatoid arthritis		
Chronic fatigue syndrome		
Food allergies		
Environmental allergies		
Multiple chemical sensitivities		
Autoimmune disease		
Immune deficiency		
Mononucleosis		
Hepatitis		
Other: _____		

MUSCULOSKELETAL	Yes	Past
Fibromyalgia		
Osteoarthritis		
Chronic pain		
Other: _____		
SKIN		
Eczema		
Psoriasis		
Acne		
Skin cancer		
Other: _____		
CARDIOVASCULAR		
Angina		
Heart attack		
Heart failure		
Hypertension (high blood pressure)		
Stroke		
High blood fats (cholesterol, tri-glycerides)		
Rheumatic fever		
Arrhythmia (irregular heart rate)		
Murmur		
Mitral valve prolapse		
Other: _____		
NEUROLOGIC/EMOTIONAL		
Epilepsy/Seizures		
ADD/ADHD		
Headaches		
Migraines		
Depression		
Anxiety		
Autism		
Multiple sclerosis		
Parkinson's disease		
Dementia		
Other: _____		
CANCER		
Lung		
Breast		
Colon		
Ovarian		
Skin		
Other: _____		



Surgical History

Please list all major and minor surgeries you have undergone with approximate dates:

Three horizontal lines for listing surgical history.

List Any Serious Accidents or Falls

Two horizontal lines for listing accidents or falls.

Early Health History

List any known problems your mother had during her pregnancy with you (illness, stress, medication, smoking, alcohol, traumatic delivery):

Horizontal line for listing pregnancy problems.

Were you breast fed? [] Yes [] No. If yes, please indicate duration if known _____

Was your home life as a child loving/supportive? [] Yes [] No

If there were significant stresses please describe

Horizontal line for describing stresses.

Please check if you had any of the following childhood illnesses:

- Checkboxes for: Frequent ear infections, Colic, Eczema, Recurrent colds, Bronchitis, Pneumonia, Meningitis, Other

As a child were you on frequent or prolonged antibiotic therapy? [] Yes [] No

Did you receive immunizations? [] Yes [] No

Did you experience any adverse reactions to immunizations? [] Yes [] No [] NA

If yes, please describe _____

Symptom Review

Please check the appropriate box for any symptoms that occur presently or have occurred in the last 6 months. Leave blank any spaces that do not apply.

Table with 4 columns: GENERAL, Mild, Moderate, Severe. Rows include Cold hands and feet, Cold intolerance, Daytime sleepiness, etc.

Table with 4 columns. Rows include Flushing, Heat intolerance, Night waking, Nightmare, Can't remember dreams, Low body temperature.

(continued)

HEAD, EYES, and EARS	Mild	Moderate	Severe
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear ringing/buzzing			
Eye crusting			
Eyelid margin redness			
Hearing loss			
Hearing problems			
Sensitivity to loud noises			
Vision problems			
MUSCULOSKELETAL	Mild	Moderate	Severe
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches:			
Around eyes			
Arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES	Mild	Moderate	Severe
Difficulty:			
Concentrating			
With balance			
With thinking			
With speech			
With memory			
Dizziness (spinning)			
Light-headedness			
Seizures			
Tingling			
Tremor/trembling			

URINARY	Mild	Moderate	Severe
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Urgency			
DIGESTION	Mild	Moderate	Severe
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of:			
Lower abdomen			
Whole abdomen			
Bloating after meals			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/ poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to:			
Lactose			
All dairy products			
Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/ jaundice (yellow eyes or skin)			
Lower abdominal pain			

(continued)

Mucus in stools			
Nausea			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
EATING	Mild	Moderate	Severe
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt cravings			
Frequent dieting			
Sweet cravings			
Caffeine dependency			
RESPIRATORY	Mild	Moderate	Severe
Bad breath			
Bad odor in nose			
Cough – dry			
Cough – productive			
Hay fever:			
Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
NAILS	Mild	Moderate	Severe
Brittle			
Curve up			
Frayed			
Fungus – fingers			
Fungus – toes			

Pitting			
Ridges			
Soft			
Thickening of:			
Finger nails			
Toenails			
White spots/lines			
LYMPH NODES	Mild	Moderate	Severe
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
SKIN, DRYNESS of	Mild	Moderate	Severe
Eyes			
Feet			
Any cracking?			
Any peeling?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
SKIN PROBLEMS	Mild	Moderate	Severe
Acne on back			
Acne on chest			
Acne on face			
Athlete's foot			
Bumps on back of upper arms			
Dark circles under eyes			
Ears get red			
Easy bruising			
Herpes – genital			
Hives			
Jock itch			
Pale skin			
Skin darkening			
Vitiligo			

(continued)

FEMALE REPRODUCTIVE	Mild	Moderate	Severe
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Yeast infections			
Unwanted hair growth			
Vaginal pain			
Premenstrual:			
Bloating			

Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
Menstrual:			
Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

Female Health History

Age at first period _____
Date of last period _____
Number of pregnancies _____
Number of live births _____
Menstrual cycle length: _____ days.
Duration of menstrual period: _____ days.
If you use birth control, what form do you use? _____

Digestive Function

Describe any food reactions you have: _____

Your usual bowel movement frequency is (*check one*):

- >2 times daily 1 time daily 1time every 2 days <1 time every 2 days.

Family Health History

Review the conditions below. Indicate if a family member has ever had a condition by marking the appropriate box with an 'X'. Leave blank any spaces that do not apply.

CONDITION current age(s) >	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
Acne						
Alcoholism/addiction						
Allergies/hay fever						
Alzheimer's Disease / Dementia						
Arthritis						
Asthma						
Autoimmune disease						
Bedwetting						
Cancer (<i>specify type _____</i>)						
Depression						
Diabetes						
Digestive problems						
Ear infections						
Female problems						
Headaches						
Heart disease						
High blood pressure						
Insomnia						
Kidney problems						
Liver disease						
Mental health problems						
Migraine						
Muscle pain/cramps						
Osteoporosis						
Spinal curve						
Thyroid problems						
Other (<i>specify _____</i>)						
Other (<i>specify _____</i>)						
If any of the above family members are deceased, specify cause of death...						
...and list their age at death						
Other pertinent family history:						

Stress Factors

Please indicate if any of the major stresses listed below apply to you (*check all that apply*):

- Job New retirement New baby Change of marital status Health problems
- Family stress Financial concerns Abusive relationship Other: _____

Please describe the quality of major relationships in your life: _____

Indicate job satisfaction: Excellent Good Fair Poor NA

Have you experienced physical, emotional, sexual, or verbal abuse? Yes No

How do you relax or relieve stress? _____

Are you currently in therapy? Yes No

 If yes, describe. _____

Lifestyle/Diet Habits

Do you have problems falling asleep? Yes No Staying asleep? Yes No

Describe your sleep pattern: Time arise _____ Time retire _____ Naps? Yes No

Your quality of sleep is: Well-rested Tired upon awakening Awaken during night

Do you: Sleep in total darkness Sleep near electric clock, outlet, or other electronic device

What is the frequency of your vacations: ____ times / year.

Do you exercise? Yes No

 If yes... Type: _____ Frequency: ____ x per week / month (*check one*).

Do you use tobacco? Yes No If yes, list amount you smoke/chew per day or week _____

 Years using tobacco _____, if you no longer use it, when did you quit _____

Do you use recreational drugs? Yes No

 If yes, list type and frequency _____

 Did you formerly use recreational drugs? Yes No If yes, specify _____

How frequently do you dine out: Daily Weekly Monthly Rarely/never

How frequently do you eat fast food: Daily Weekly Monthly Rarely/never

How much water do you drink daily: < 1 qt. 1 qt. 2 qt. > 2qt.

 Is it filtered water? Yes No

Foods you avoid and why

 (*i.e.* allergies, diet, dislike): _____

Foods you crave: _____

Do you have (or have you had) an eating disorder? Yes No

Do you drink coffee? Yes No

If yes, how many daily cups daily of decaf? _____ and caffeinated? _____

Do you drink tea? Yes No

If yes, what kind? _____ and how many cups do you drink daily? _____

Do you drink soda? Yes No

If yes, what kind? _____ and how many do you drink daily? _____

Do you drink alcohol? Yes No

If yes, list type and amount per day and week _____

Do you have (or have you had) a problem with alcohol or drug overuse? Yes No

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

- Significantly modify your diet 5 4 3 2 1
- Take several nutritional supplements each day 5 4 3 2 1
- Keep a record of everything you eat each day 5 4 3 2 1
- Modify your lifestyle (e.g., work demands, sleep habits) 5 4 3 2 1
- Practice a relaxation technique 5 4 3 2 1
- Engage in regular exercise 5 4 3 2 1

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health-related activities? 5 4 3 2 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through? _____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? 5 4 3 2 1

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as a you implement your personal health program? 5 4 3 2 1

Comments _____

When was the last time you felt well? _____

Are there any other health goals you would like to achieve?

Is there anything else you would like to add?