

9. Family History:	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

10. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

11. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____

13. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension

14. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

15. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any you've experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness
 Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems
 Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

16. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems: _____		

17. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure	
Palpitations/Fluttering	Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins

18. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain	Passing Gas	Heartburn
Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C	Hemorrhoids	Abdominal Pain

19. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease	Painful Urination	Frequent UTI	Frequent Urination	Heavy Flow
Kidney Stones	Impaired Urination	Blood in Urine	Frequent Urination at Night	

20. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Clotting	Bleeding Between Cycles
Menopausal Symptoms	Difficulty Conceiving	Painful Periods	

21. **Menstrual/Birthing History:**

1. Age of First Menses: _____	4. Birth Control Type: _____	7. # of Live Births: _____
2. # of Days of Menses: _____	5. # of Pregnancies: _____	
3. Length of Cycle: _____	6. # of Miscarriages: _____	

22. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties	Prostrate Problems	Testicular Pain/Swelling	Penile Discharge
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23. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain	Muscle Spasms/Cramps	Arm Pain	Upper Back Pain	Mid Back Pain
Low Back Pain	Leg Pain	Joint Pain (if so, where?): _____		

24. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness	Paralysis	Numbness/Tingling	Loss of Balance	Seizures/Epilepsy
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25. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid	Hypoglycemia	Hyperthyroid	Diabetes Mellitus	Night Sweats	Feeling Hot or Cold
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26. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

27. Lifestyle:

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Typical diet: breakfast, lunch, dinner and any snacks _____

c. Exercise routine: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

g. Nicotine/Alcohol/Caffeine Use: _____

h. Have you experienced any major traumas? Y N Explain: _____

i. How many glasses of water or non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Leisure activities, interests, and hobbies: _____

How did you hear about this practitioner? _____