

Hormonal Balance Clinic Medical Health History

After completing the Medical History form, please mail it back to our office or bring it with you to your visit. The cost of the initial consultation is \$225.00. The duration of the initial consultation will be a minimum of one and a half hours.

Please note that our office policy states that **appointments canceled without 24 hours notice must be paid in full** before scheduling an additional visit.

Please bring all prescribed medicine, nutritional supplements and all other items you are currently taking along with any recent blood, saliva and urine tests results.

Our Office address and phone number is listed below;

Hormonal Balance Clinic
Office of Steve Hines N.D., N.E.
2118 W Beauregard Ave.
San Angelo, Texas 76901

(325) 947-5266
(325) 223-2853 Fax



MEDICAL HEALTH HISTORY

DATE _____

NAME _____
(LAST) (FIRST) (M.I.)

SEX: M F

CURRENT BLOOD PRESSURE ____/____ (REQUIRED)

ADDRESS _____
CITY _____ STATE _____
ZIP _____
PHONE # _____
E-MAIL _____

DESCRIBE IN DETAIL _____

AGE _____ BIRTH DATE ____/____/____
BIRTHPLACE _____

DATE OF ONSET _____

HEIGHT ____ WEIGHT ____ LBS ____

HOW DID IT BEGIN? _____

SINGLE MARRIED
DIVORCED WIDOWED

YOUR OCCUPATION _____

UNDER WHAT CIRCUMSTANCES DOES IT OCCUR?

PREVIOUS OCCUPATIONS _____

EDUCATION IN YEARS _____
HIGH SCHOOL _____
COLLEGE _____ POST GRAD _____

FREQUENCY _____

SEVERITY & DURATION _____

STATES OR COUNTRIES WHERE YOU HAVE
LIVED _____

WHAT TREATMENT HAVE YOU HAD FOR THIS
PROBLEM? _____

WHAT ARE YOUR HOBBIES? _____

CURRENT HEALTH PROBLEMS

MAIN COMPLAINT _____

DIAGNOSED DISEASES

MEDICAL HEALTH HISTORY

PRACTITIONERS NAME:

PRIMARY DOCTOR: _____

SPECIALIST _____

DIAGNOSTIC CODE(S)

LAST COMPLETE PHYSICAL EXAM

WHERE? _____

WHEN? _____

MEDICATION & DOSAGES: _____

ANY OTHER PERTINENT INFORMATION:

LIST ANY OTHER MEDICAL PROBLEMS
WITH DATE OF ONSET

DATE	PROBLEM
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

LIST ALL MAJOR ILLNESSES AND AGE THEY
OCCURRED

AGE	ILLNESS
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

CHECK IF YOU'VE HAD:

- BIRTH DEFECTS
- FEEDING PROBLEMS
- BIRTH INJURIES

HAVE YOU EVER USED TOBACCO PRODUCTS

Yes No

DO YOU USE TOBACCO NOW?

Yes No

AMOUNT/FREQUENCY _____

- CIGARETTES
- PIPE
- CHEWING TOBACCO
- CIGARS

CHECK THE FOLLOWING IF YOU HAVE EVER HAD

THESE VACCINATIONS

- SMALL POX DATE _____
- POLIO DATE _____
- MUMPS DATE _____
- DPT OR DATE _____

TETANUS TOXIN

COMMUNICABLE DISEASES

CHECK DISEASES YOU HAVE HAD

- CHICKEN POX
- DIPHThERIA
- GERMAN MEASLES
- GONORRHEA
- HEPATITIS
- HERPES SIMPLEX
- HIV
- INFLUENZA
- MEASLES
- MENINGITIS
- MONONUCLEOSIS
- MUMPS
- POLIO
- SCARLET FEVER
- SHINGLES
- SYPHILIS
- TUBERCULOSIS
- WHOOPING COUGH
- OTHER _____

MEDICAL HEALTH HISTORY

ENDOCRINE

CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- ABNORMAL THIRST
- CRAMPS IN LEGS
- DIABETES OR SUGAR IN URINE
- ENLARGED THYROID/GOITER
- HYPOGLYCEMIA
- LACK OF APPETITE
- NOTICEABLE INCREASE IN APPETITE

LIST MEDICAL EMERGENCIES THAT REQUIRED TREATMENT

	DATE
_____	_____
_____	_____
_____	_____
_____	_____

CHECK IF YOU HAVE HAD X-RAYS OF ANY OF THE FOLLOWING:

- OVERACTIVE THYROID
- SWELLING
- UNDER-ACTIVE THYROID KIDNEYS
- WEIGHT *GAIN* OF MORE THAN FIVE POUNDS IN THE LAST 12 MONTHS
- WEIGHT *LOSS* OF MORE THAN FIVE POUNDS IN THE LAST 12 MONTHS SPINE

	DATE
CHEST _____	_____
COLON _____	_____
SKULL _____	_____
EXTREMITIES _____	_____
GALL BLADDER _____	_____
STOMACH _____	_____
OTHER _____	_____

SURGICAL HISTORY

CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING SURGERIES. NOTE THE YEAR PERFORMED.

	YEAR
APPENDECTOMY _____	_____
BRAIN _____	_____
CANCER _____	_____
EAR _____	_____
EYE _____	_____
GALL BLADDER _____	_____
HEART _____	_____
HEMORRHOID _____	_____
HERNIA _____	_____
HYSTERECTOMY _____	_____
FEMALE OTHER _____	_____
LUNG _____	_____
MASTOID _____	_____
PROSTATE _____	_____
MALE OTHER _____	_____
SKIN _____	_____
STOMACH _____	_____
TONSILLECTOMY _____	_____

HAVE YOU HAD ANY OF THE FOLLOWING?

BONE SCAN _____	_____
EKG _____	_____
BRAIN SCAN _____	_____
STRESS EKG _____	_____
CAT SCAN _____	_____
THYROID SCAN _____	_____
RESULTS _____	_____

OTHER CONDITIONS

CHECK IF YOU HAVE EXPERIENCED THE FOLLOWING:

- ANAPHYLAXIS
- ARTHRITIS
- CONVULSIONS
- DIABETES
- EMPHYSEMA
- HEART ATTACK
- HIGH BLOOD PRESSURE
- LOSS OF CONSCIOUSNESS
- LOW BLOOD PRESSURE
- PARALYSIS
- PEPTIC ULCER
- PNEUMONIA
- PSYCHIATRIC CARE
- SEVERE DIZZY SPELLS
- TUBERCULOSIS
- SEVERE REACTION TO ALLERGY TESTS/SHOTS

HOSPITALIZATION

LIST REASON, LENGTH OF STAY, AND DATES.

	DATE
_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL HEALTH HISTORY

FAMILY INFORMATION

FATHER

PRESENT AGE IF LIVING _____
GENERAL STATE OF HEALTH _____
IF DECEASED, AGE AT DEATH _____
CAUSE OF DEATH _____

CHECK WHAT APPLIES

HUSBAND

WIFE

PARTNER

PRESENT AGE IF LIVING _____

GENERAL STATE OF HEALTH _____

IF DECEASED, AGE AT DEATH _____

CAUSE OF DEATH _____

MOTHER

PRESENT AGE IF LIVING _____
GENERAL STATE OF HEALTH _____
IF DECEASED, AGE AT DEATH _____
CAUSE OF DEATH _____

FAMILY HISTORY

CHECK ANY OF THE FOLLOWING THAT HAVE OCCURRED

IN YOUR FAMILY

ALCOHOLISM

ARTHRITIS

ASTHMA

CANCER

CHRONIC FATIGUE

CONSTIPATION

DEPRESSION

DIARRHEA

DRUG ABUSE

EMPHYSEMA

EPILEPSY

HEART DISEASE

HIVES

HYPOLYCEMIA

INDIGESTION

INSANITY

INSECT ALLERGY

MIGRAINE

NERVOUSNESS

PEPTIC ULCER

TUBERCULOSIS

VERTIGO

SISTERS & BROTHERS

(PLEASE NOTE IF BROTHER OR SISTER)

#1 _____

PRESENT AGE IF LIVING _____

GENERAL STATE OF HEALTH _____

IF DECEASED, AGE OF DEATH _____

CAUSE OF DEATH _____

DIABETES

#2 _____

PRESENT AGE IF LIVING _____

GENERAL STATE OF HEALTH _____

IF DECEASED, AGE AT DEATH _____

CAUSE OF DEATH _____

DRUG ALLERGY

ECZEMA

#3 _____

GENERAL STATE OF HEALTH _____

HAY FEVER

PRESENT AGE IF LIVING _____

IF DECEASED, AGE AT DEATH _____

CAUSE OF DEATH _____

HIGH BLOOD PRESSURE

(PLEASE NOTE IF SON OR DAUGHTER)

#1 _____

PRESENT AGE IF LIVING _____

GENERAL STATE OF HEALTH _____

IF DECEASED, AGE AT DEATH _____

CAUSE OF DEATH _____

KIDNEY DISEASE

LOW BLOOD PRESSURE

#2 _____

PRESENT AGE IF LIVING _____

GENERAL STATE OF HEALTH _____

IF DECEASED, AGE AT DEATH _____

CAUSE OF DEATH _____

PSYCHIATRIC CARE

SCHIZOPHRENIA

STROKE

#3 _____

PRESENT AGE IF LIVING _____

GENERAL STATE OF HEALTH _____

IF DECEASED, AGE AT DEATH _____

CAUSE OF DEATH _____

OTHER _____

TYPE OF CANCER _____

SONS & DAUGHTERS

MEDICAL HEALTH HISTORY**EYES**

CHECK ANY OF THE FOLLOWING THAT YOU HAVE EXPERIENCED

BLOODSHOT
 BLURRED VISION
 BURNING
 CATARACTS
 CRUSTY LIDS
 DARK CIRCLES
 DRYNESS
 FLOATERS
 FREQUENT BLINKING
 GLAUCOMA
 GRANULATED LID
 IRRITATED
 ITCHING
 MUCUS IN EYE
 PUFFY UNDER EYE
 SENSITIVE TO LIGHT
 STIES
 SWELLING OF LIDS
 TUNNEL VISION
 TWITCHING LIDS
 WATERING
 OTHER _____

ARE THESE PROBLEMS PRESENT ALL YEAR?
 (CIRCLE ONE) YES NO

IF NOT, WHICH SEASON ARE THEY MOST PRESENT?

SUMMER
 FALL
 WINTER
 SPRING

EARS

CRUSTING INSIDE
 DIZZINESS
 DRAINAGE
 EUSTACHIAN BLOCK
 EVER LANCED
 FLOATING SENSATION
 FLUID ACCUMULATION
 FREQUENT INFECTIONS
 HEARING AID
 HEARING LOSS
 ITCHING INSIDE
 ITCHING OUTSIDE
 LOSS OF BALANCE
 NERVE DEAFNESS

EARS (CONTINUED)

PRESSURE
 RINGING
 PAIN
 ROARING
 TUBES IN EAR
 OTHER _____

ARE THESE PROBLEMS PRESENT ALL
 YEAR? (CIRCLE ONE) YES NO

IF NOT, IN WHICH SEASON ARE THEY
 MOST PRESENT?

SUMMER
 FALL
 WINTER
 SPRING

NOSE

BLEEDING
 BLISTERS
 BLOCKAGE
 BURNING
 CRUSTING
 DRIPPING/RUNNING
 ITCHING
 MUCUS BLOODY
 MUCUS YELLOW
 NO SENSE OF SMELL
 PAIN
 POLYPS
 POST NASAL DRIP
 REQUIRE NOSE DROPS
 SENSITIVE TO ODORS
 SINUS INFECTIONS
 SNEEZING
 OTHER _____

ARE THESE PROBLEMS PRESENT ALL YEAR?
 (CIRCLE ONE) YES NO

IF NOT, IN WHICH SEASON ARE THEY MOST
 PRESENT?

SUMMER
 FALL
 WINTER
 SPRING

MEDICAL HEALTH HISTORY**NOSE (CONTINUED)**

MOST COMMON UPON:

ARISING
 AFTER MEALS
 AFTER MEDICATION
 AT NIGHT
 COLD WEATHER
 DRY WEATHER
 HUMID WEATHER
 HOT WEATHER
 LYING DOWN

MOUTH & THROAT

CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED

BAD BREATH
 BAD TASTE
 CANKER SORES
 CHAPPED LIPS
 COATED TONGUE
 CRACKS IN TONGUE
 DENTURES
 DIFFICULTY SWALLOWING
 FEVER BLISTERS
 GRIND TEETH
 GAG EASILY
 HOARSE
 LIPS CRACK IN CORNERS
 LIPS SWELL
 METALLIC TASTE
 NECK GLANDS SWELL
 POSTNASAL DRIP
 PURPLISH COLOR TONGUE
 SLEEP WITH MOUTH OPEN
 SNORING
 SORE/RAW TONGUE
 SORE THROAT
 THROAT CLEARING
 THROAT CLOSING
 THROAT PALATE ITCHES
 TONGUE SWOLLEN
 VOICE LOSS
 OTHER _____

CARDIAC & RESPIRATORY

CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED

ANGINA
 ASTHMA
 BRONCHITIS
 CHEST PAIN

CARDIAC & RESPIRATOR (CONTINUED)

CHEST TIGHTNESS
 COUGHING MUCUS
 CROUP
 DRY COUGH
 ENLARGED HEART
 FLUSHING
 FREQUENT COLDS
 FREQUENT COUGHS
 FREQUENT INFECTIONS
 HEART ATTACK
 HEAVINESS IN CHEST
 LEG CRAMPS
 MURMUR
 NIGHT SWEATS
 PNEUMONIA
 RAPID HEART
 SHORTNESS OF BREATH
 SKIPPED BEATS
 STROKE
 SWOLLEN ANKLES

TINGLING

WHEEZING

OTHER _____

HOW FAR CAN YOU WALK VIGOROUSLY BEFORE
 BECOMING SHORT OF BREATH? _____

HOW FAR CAN YOU WALK VIGOROUSLY BEFORE
 LEG CRAMPS DEVELOP? _____

WHAT IS YOUR MAIN CARDIAC & RESPIRATORY
 PROBLEM? _____

WHEN IS IT WORSE?

AFTERNOON

BEFORE LUNCH

FALL

MORNING

NIGHT

SPRING

SUMMER

WINTER

YEAR 'ROUND

LIST CURRENT HEART MEDICATIONS:

MEDICAL HEALTH HISTORY

GASTROINTESTINAL

CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED

- ANAL ITCHING
- ANAL PAIN
- BELCH FREQUENTLY
- BLOATING
- BLOODY STOOL
- CONSTIPATED
- CRAMPING
- CRAVE SWEETS
- DARK STOOL
- DIARRHEA
- FAT INTOLERANCE
- FRAGMENTED STOOL
- FREQUENT NAUSEA
- FREQUENT VOMITING
- GALLBLADDER TROUBLE
- GOOD APPETITE
- HEARTBURN
- INDIGESTION
- LARGE BULKY STOOL
- LIGHT COLORED STOOL
- MUCUS IN STOOL
- PICKY EATER
- POOR APPETITE
- QUEASY STOMACH
- RECTAL BLEEDING
- RETASTE FOOD
- ROUGHAGE INTOLERANCE
- STOMACH ACHES
- STOOL FLOATS
- STOOL STINKS
- STRONG STOOL ODOR
- TARRY STOOL
- ULCER
- USE LAXATIVES
- VOMIT BLOOD

OTHER _____

HOW OFTEN DO YOUR BOWELS MOVE?

MUSCULOSKELETAL

DO YOU HAVE JOINT MUSCLE PAIN?

(CIRCLE ONE) YES NO

HOW SEVERE? _____

JOINT SWELLING? _____

(CIRCLE ONE) YES NO

HAS FLUID BEEN REMOVED?

(CIRCLE ONE) YES NO

WHEN DID PAIN OR SWELLING BEGIN?

IS IT CONSTANT OR DOES IT VARY?

DO YOU HAVE MORNING STIFFNESS?

(CIRCLE ONE) YES NO

HOW LONG DOES IT LAST?

WERE YOU EVER DIAGNOSED WITH ANY OF THE
THE FOLLOWING?

AUTOIMMUNE DISEASE

COLLAGEN

LUPUS

MULTIPLE SCLEROSIS

MUSCULAR DYSTROPHY

OSTEOARTHRITIS

RHEUMATIC FEVER

RHEUMATOID ARTHRITIS

VASCULAR DISEASE

OTHER _____

CONTACT DERMATITIS

DO YOU HAVE A REACTION TO CONTACT WITH
ANY SUBSTANCE?

(CIRCLE ONE) YES NO

WHICH SUBSANCES? _____

PART OF BODY AFFECTED? _____

MEDICAL HEALTH HISTORY

CONTACT DERMATITIS (CONTINUED)

WHAT TREATMENT HAS BEEN USED?

CHECK IF YOU HAVE EVER HAD:

- POISON IVY
 - POISON OAK
 - POISON SUMAC
 - OTHER _____
- _____

DOES CONTACT WITH METAL ON YOUR SKIN CAUSE BREAKING OUT?

(CIRCLE ONE) YES NO

SKIN & HAIR

CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED

- ADULT ACNE
- ATHLETES FOOT
- BLANCHING
- BOILS
- BRITTLE NAILS
- BRUISE EASILY
- BURNING FEET
- CRACKING
- CUTS HEAL SLOWLY
- DRYNESS
- DULL HAIR
- DANDRUFF
- ECZEMA
- EXCESS HAIR LOSS
- FLUSH EASILY
- FOOT ODORS
- FUNGUS/NAILS
- FUNGUS/SKIN
- GENITAL HERPES
- GOOSEFLESH COMMON
- HERPES SIMPLEX
- HIVES
- ITCHING
- LUMPS
- NODES
- OILINESS
- PEELING
- RASH
- REDNESS
- RIDGED NAILS

SKIN & HAIR (CONTINUED)

- RINGWORM
- SCALY LESIONS
- SHINGLES
- SORES
- SWEATY PALMS

TEENAGE ACNE

- WHITE SPOTS ON NAILS
 - OTHER _____
- _____

LIST MAIN AREAS INVOLVED _____

IS YOUR SKIN SENSITIVE TO:

THE SUN

FABRICS

DETERGENTS

OTHER

WHERE? _____

FREQUENCY? _____

INSECT SENSITIVITY

LIST ANY INSECTS THAT CAUSE A MORE SEVERE

REACTION THAN NORMAL _____

CHECK ANY REACTIONS YOU MAY HAVE TO

INSECT STINGS OR BITES

ANAPHYLAXIS

DIFFICULTY BREATHING

DIFFICULTY SWALLOWING

DIZZINESS

FAINTING

HIVES

LOCAL SWELLING

LOSS OF CONSCIOUSNESS

MEDICAL HEALTH HISTORY

INSECT SENSITIVITY (CONTINUED)

MENTAL CONFUSION
 NAUSEA
 SHOCK
 VOMITING
 OTHER _____

DID IT REQUIRE HOSPITALIZATION?
 (CIRCLE ONE) YES NO

DO INSECTS SEEM TO SINGLE YOU OUT?
 (CIRCLE ONE) YES NO

WHICH INSECTS?

HOW MANY REACTIONS HAVE YOU HAD? _____

WHAT TYPE OF TREATMENT DO YOU RECEIVE AFTER
 EACH REACTION? _____

URINARY & GENITALIA

CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED

BEDWETTING
 BLADDER DISEASE
 BLADDER INFECTION
 BURNING
 CANCER *
 CYSTITIS
 DIFFICULTY URINATING
 DISCHARGE
 FREQUENT URINATION
 FRIGIDITY
 GENITAL HERPES
 IMPOTENCE
 ITCHING
 KIDNEY DISEASE
 KIDNEY INFECTION
 KIDNEY STONES
 LACK OF CONTROL
 PAINFUL URINATION

URINARY & GENITALIA (CONTINUED)

PASS BLOOD
 PROSTATE TROUBLE
 SORES
 SPOUSE TREATED FOR TRICHOMONAS
 TREATED FOR INFECTION
 TREATED FOR YEAST INFECTION
 TRICHOMONAS (SELF)
 TRICHOMONAS TREATED
 YEAST INFECTION

OTHER _____

* LOCATION OF CANCER _____

YEAR DIAGNOSED/TREATED _____

HEADACHE & CEREBRAL

CHECK ANY OF THE FOLLOWING TYPES OF
 HEADACHE PAIN YOU HAVE EXPERIENCED:

ACUTE
 BAND-LIKE
 BORING
 BURNING
 CAP-LIKE

CONSTANT

CONSTRICTION
 CRAMP-LIKE

CUTTING

DRAWING
 DULL
 EPISODIC
 EXCRUCIATING

HEAVINESS
 PRESSURE

PULSATING
 SHARP

SORENESS
 THROBBING

TIGHT

WISE-LIKE

OTHER _____

MEDICAL HEALTH HISTORY

HEADACHE & CEREBRAL (CONTINUED)

CHECK LOCATION OF PAIN

- BACK OF EYE
- BACK OF HEAD
- BACK OF NECK
- CHEEK
- CROWN
- FOREHEAD
- LEFT SIDE OF HEAD
- RIGHT SIDE OF HEAD
- TOP OF HEAD
- UPPER TEETH

OTHER _____

CHECK ANY OF THE FOLLOWING THAT ARE ASSOCIATED WITH THE HEADACHE

- ABDOMINAL PAIN
- BEGINS SLOWLY
- BEGINS SUDDENLY
- CHILLY SENSATION
- CLEARs COMPLETELY
- CLEARs WITH TREATMENT
- DAZZLING LIGHTS
- DIARRHEA
- EPISODIC
- FLUSHING
- INFLAMED EYE
- LASTS FOR DAYS
- LASTS HOURS
- LASTS SECONDS
- LOSS OF SIGHT
- NASAL BLOCKAGE
- NAUSEA
- NECK/SHOULDER PAIN
- PALLOR
- QUEASY STOMACH
- RELIEVED BY WALKING
- RETURNS REGULARLY
- RUNNING NOSE
- SWELLING OF EYE
- TEARING
- VISUAL DISTURBANCE
- VOMITING
- WORSE LYING DOWN
- OTHER _____

CHECK ANY OF THE FOLLOWING THAT PROCEED OR INTENSIFY PAIN

- ALCOHOL
- ANGER
- ANXIETY
- ARGUMENTS
- CHILLING
- COFFEE/TEA
- DISAPPOINTMENT
- EXERCISE
- EYE STRAIN
- INFECTIONS
- FASTING
- FOODS
- HUMIDITY
- INTENSE LIGHT
- MOTION
- MUSCLE STRAIN
- NOISE
- ODORS
- OVERHEATING
- REJECTION
- UNUSUAL STIMULATION
- OTHER _____

CHECK WHEN YOU HEADACHE USUALLY OCCURS

- AFTER BREAKFAST
- AFTER LUNCH
- AFTER SUPPER
- BEFORE BREAKFAST
- BEFORE LUNCH
- BEFORE PERIOD
- BEFORE SUPPER
- DURING
- MENSTRUATION
- DURING SLEEP
- ON ARISING
- WHEN LYING DOWN
- SUMMER
- FALL
- WINTER
- SPRING

OTHER _____

AT WHAT AGE DID HEADACHES BEGIN? _____

MEDICAL HEALTH HISTORY

HEADACHE & CEREBRAL (CONTINUED)

CHECK ANY OF THE FOLLOWING THAT APPLY WHEN YOU HAVE A HEADACHE:

- APPLY HOT/COLD COMPRESS
- APPLY PRESSURE TO HEAD
- CAN KEEP WORKING
- CANNOT KEEP WORKING
- REQUIRE BED REST
- REQUIRE DARKNESS
- REQUIRE EYE COVERING
- REQUIRE HOSPITALIZATION

OTHER _____

CHECK IF YOU HAVE EVER EXPERIENCED ANY OF THE FOLLOWING:

- BACK /NECK INJURY
- BEEN KNOCKED UNCONSCIOUS
- DENTAL OCCLUSION
- ENCEPHALITIS
- HEAD INJURY
- REGULAR DENTAL CARE
- SKULL FRACTURE

OTHER _____

CHECK ANY OF THE FOLLOWING FOUND IN YOUR FAMILY:

- BRAIN TUMORS
- CHEMICAL ALLERGIES
- EMOTIONAL PROBLEMS
- FOOD ALLERGIES
- HEADACHES
- INHALANT ALLERGIES
- NERVOUS BREAKDOWN
- UNDUE FATIGUE

DO YOU HAVE ANY CAUSES FOR HEADACHES?

(CIRCLE ONE) YES NO

IF YES, EXPLAIN _____

HAVE YOU BEEN HOSPITALIZED FOR A HEADACHE?

(CIRCLE ONE) YES NO

IF YES, WHEN? _____

WHAT TREATMENT HAVE YOU RECEIVED FOR HEADACHES? _____

LIST MEDICATIONS YOU TAKE FOR YOUR

HEADACHE: _____

PSYCHOLOGICAL HISTORY

CHECK THOSE THAT APPLY

- AGGRESSIVENESS
- ALCOHOL ABUSE
- AMNESIA
- ANXIETY
- BLACKOUTS
- CLUMSINESS
- COLD SWEATS
- CONCENTRATION
- CONSIDERED NERVOUS
- CONTROLLED BY OTHER FORCES
- CONVULSIONS
- CRY OFTEN
- DAYTIME SLEEPINESS
- DEPRESSION
- DIFFICULTY FALLING ASLEEP
- DIFFICULTY STAYING AWAKE
- DIZZINESS
- DRUG ADDICTION
- EASILY ANGERED
- EXTREMELY SHY/SENSITIVE
- FAINTING
- FAMILY MEMBER/NERVOUS BREAKDOWN
- FEELING OF HOSTILITY
- FEEL LOST MOST OF THE TIME
- FORGETFUL
- FREQUENTLY KEYED UP/JITTERY
- FRUSTRATION
- GO TO PIECES EASILY
- GROGGINESS
- HAD NERVOUS BREAKDOWN
- HEARD VOICES
- HOSPITALIZED FOR NERVES
- INCESSANT TALKER
- INNER TREMBLING
- INSECURITY

MEDICAL HEALTH HISTORY

PSYCHOLOGICAL HISTORY (CONTINUED)

- INSECURITY
- IRRITABILITY
- LISTLESSNESS
- MISUNDERSTOOD BY OTHERS
- NUMBNESS
- OFTEN FEEL SUDDENLY SCARED
- OFTEN UNABLE TO WORK
- OFTEN UNHAPPY
- PALE COMPLEXION
- PERFECTIONIST
- POOR MUSCLE CONDITION
- PROFUSE SWEATING
- RESTLESS LEGS
- SHAKINESS
- SHOCK THERAPY
- SHORT ATTENTION SPAN
- SLEEP WALKING
- STARTLED BY NOISES
- STUPOROUS
- UNABLE TO CONCENTRATE
- UNABLE TO REASON
- UNDUE FATIGUE
- UNUSUAL TENSION
- USE TRANQUILIZERS
- VISION CHANGES
- WITHDRAWN FEELING
- WORRIED BY LITTLE THINGS
- WORKAHOLIC

OTHER _____

CHILDHOOD

AS AN INFANT, DID YOU HAVE ANY OF THE FOLLOWING:

- BEDWETTING
- CAR SICKNESS
- CLUMSY/UNCOORDINATED
- DISCIPLINE PROBLEM
- DYSLEXIA
- FINICKY APPETITE
- HAD FEW FRIENDS
- HEAD & NECK PAIN
- HEADACHES
- HYPERACTIVITY/ATTENTION DEFICIT DISORDER
- INTENSE TEMPER/FURY
- MARKEDLY SHY/TIMID
- READING PROBLEMS
- SLOW TO LEARN

CHILDHOOD (CONTINUED)

- SWEATS/SLEEPING
- TROUBLE SLEEPING
- UNABLE TO GAIN WEIGHT
- USUALLY MEDDLESOME
- WHINY/BAD TEMPERED
- WRITING PROBLEMS
- OTHER _____

AS AN INFANT, DID YOU HAVE ANY OF THE FOLLOWING:

- BEHAVIOR PROBLEMS
- BOTTLE FED
- COLIC
- CONSTANT HUNGER
- CONSTANT CONSTIPATION
- DIARRHEA
- EAR INFECTION
- ECZEMA
- FAILURE TO THRIVE
- FUSSINESS
- GASSINESS
- HYPERACTIVITY
- LEARNING PROBLEMS
- LEG ACHES
- NIGHT SWEATS
- PICKY EATER
- POOR APPETITE
- RECURRENT INFECTION
- SKIN RASH
- STOMACH ACHES
- VOMITING

WOMEN ONLY

CHECK IF YOU HAVE EVER EXPERIENCED ANY OF THE FOLLOWING:

- BREAST BIOPSY
- BREAST CYSTS OR LUMPS
- BREAST SORENESS DURING PERIOD
- BREAST SORENESS NRELATED TO PERIOD
- MASTECTOMY
- EXCESSIVE HAIR GROWTH (FACE, BREASTS)
- PROBLEMS WITH INFANTS _____
- _____
- _____

MEDICAL HEALTH HISTORY

WOMEN ONLY (CONTINUED)

NUMBER OF CHILDREN _____

NORMAL BIRTHS _____

NORMAL PREGNANCY?

(CIRCLE ONE) YES NO

IF NOT, EXPLAIN _____

DIFFICULT LABOR?

(CIRCLE ONE) YES NO

IF YES, EXPLAIN _____

WHAT TREATMENT DID YOU RECEIVE? _____

BIRTHWEIGHTS:

NUMBER OF MISCARRIAGES _____

REASON(S) _____

MENSES

AGE AT ONSET _____

HAD D&C

HEAVY FLOW

HYSTERECTOMY

IRREGULAR PERIODS

MISCARRIAGE

NOW PREGNANT

PARTIAL HYSTERECTOMY

PMS

REGULAR PERIODS

SCANT FLOW

TRYING TO GET PREGNANT

USE BIRTH CONTROL PILLS

USE DIAPHRAGM

USE DOUCHES

MENSES (CONTINUED)

USE FOAM

USE IUD

USE LUBRICANTS

OTHER

(INCLUDE FEMALE SURGERIES) _____

WHAT PROBLEMS DO YOU HAVE BEFORE PERIODS? _____

DURATION _____

WHAT PROBLEMS DO YOU HAVE DURING OVULATION? (MIDDLE OF CYCLE) _____

DURATION _____

MENOPAUSE

AGE AT MENOPAUSE _____

TAKING HORMONES? YES NO (CIRCLE ONE)

HOW LONG? _____

ALLERGY TREATMENT

HAVE YOU HAD ALLERGY TESTS?

YES NO (CIRCLE ONE)

WHEN? _____

WHERE? _____

WHAT TYPE? _____

PHYSICIAN'S NAME: _____

ARE YOU TAKING ALLERGY MEDICATIONS OR INJECTIONS NOW? YES NO (CIRCLE ONE)

WHAT TYPE? _____

MEDICAL HEALTH HISTORY

ALLERGY TREATMENT (CONTINUED)

ADRENALINE INJECTIONS FOR ALLERGIES REQUIRED?
 YES NO NUMBER OF TIMES _____

EMERGENCY TREATMENT FOR ALLERGIES REQUIRED?
 YES NO NUMBER OF TIMES _____

- CONSTRUCTION WORKER
- FARM WORKER
- HOUSE WORKER
- PAINTER
- HOSPITAL WORKER
- WORK INDOORS
- WORK OUTDOORS
- WORK AROUND DUST
- WORK WITH ANIMALS
- WORK WITH COSMETICS
- WORK IN EXTREME HEAT
- WORK IN EXTREME COLD
- WORK AROUND NOXIOUS FUMES

INHALANT AND CHEMICAL HISTORY

OCCUPATIONAL INFORMATION

- TEACHER
- PROFESSIONAL
- SALESPERSON
- PAINTER
- OFFICE WORKER
- FACTORY WORKER

AT WORK, DO YOU FEEL

- BETTER
- WORSE
- SAME

INHALANT & CHEMICAL HISTORY

CHECK ANY OF THE FOLLOWING THAT CAUSE IRRITATION

ALCOHOL ARTIST SUPPLIES BIRD INSIDE CAT INSIDE CENTRAL HEATING/COOLING CHEMICALS COSMETICS COTTON DEODORANTS DETERGENTS DIESEL FUEL DISINFECTANTS DOG INSIDE DRAPES DUST DYES EXHAUST FUMES EYE MAKEUP FEATHERS FERTILIZERS FIREPLACE FLOOR FURNACE FLOOR WAX FRESH NEWSPAPERS	FURNITURE POLISH GASOLINE FUMES GAS STOVE/HEAT GLUE GRAIN DUST HAIRSPRAY HEMP HERBICIDES INCENSE INSECTICIDES KAPOK LACQUERS MARSHY AREAS MILDEW MOLDS MOTHBALLS NAIL POLISH NEW CARPET OLD CARPET NEW HOME OLD HOME NEWSPRINT OLD MAGAZINES OVERSTUFFED FURNITURE	PAINTS PERFUMES PHOTOCOPY PAPER PLASTIC POTTED PLANTS RAISED HOME RUBBER RUGS SISAL SLAB HOME SOAPS SOLVENTS SPACE HEATERS TAR TOBACCO SMOKE TURPENTINE VARNISHES WOODED AREAS WOOD SMOKE OTHER _____ _____ _____ _____ _____
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MEDICAL HEALTH HISTORY

INHALANT & CHEMICAL HISTORY (CONTINUED)

CHECK IF YOU HAVE HAD REACTIONS IN THE
IN THE FOLLOWING CONDITIONS

- SPRING
- SUMMER
- FALL
- WINTER
- YEAR LONG
- WHEN TOO HOT
- WHEN TOO COLD
- HUMID WEATHER
- WINDY WEATHER
- WORSE AT DAYTIME
- WORSE AT NIGHT
- CERTAIN ROOMS
- IN MOLDY PLACES
- SPECIFIC ODORS
- FROM DYES
- HOUSE CLEANING
- PHYSICAL EXERTION
- WHEN CUTTING GRASS
- RAKING LEAVES
- OTHER _____

LIST FAMILY HOBBIES

NOTE NAME BRANDS OF ANY PRODUCTS YOU
USE REGULARLY

- AFTER SHAVE _____
- BREATH FRESHENERS _____
- CHAPSTICK _____
- CHEWING GUM _____
- COUGH DROPS _____
- DENTAL ADHESIVE _____
- DENTIFRICE _____
- FABRIC SOFTENER _____
- LAUNDRY DETERGENT _____
- LIPSTICK _____
- MOUTHWASH _____
- PERFUME _____
- TOOTHPASTE _____
- OTHER _____

ENVIRONMENT

DO YOU LIVE IN AN APARTMENT?
(CIRCLE ONE) YES NO

AGE OF APARTMENT _____

DO YOU LIVE IN A HOUSE?
(CIRCLE ONE) YES NO

AGE OF HOUSE _____

DOES YOUR HOUSE TEND TO GET DUSTIER
THAN OTHER HOMES?
(CIRCLE ONE) YES NO

HEATING SYSTEM

- ELECTRIC BASEBOARD
- ELECTRIC PANEL
- FIREPLACE
- FLOOR FURNACE
- GAS FURNACE
- HOT WATER HEATER
- OIL FURNACE
- RADIATOR STEAM HEAT
- SPACE HEATER
- WALL FURNACE
- WOOD STOVE
- OTHER _____

PILLOWS

- DOWN
- FEATHER
- FOAM RUBBER
- KAPOK
- SYNTHETIC
- OTHER _____

ROOMMATE'S PILLOW

- DOWN
- FEATHER
- FOAM RUBBER
- KAPOK
- SYNTHETIC
- OTHER _____

MEDICAL HEALTH HISTORY

MATTRESS

BOX SPRING
 FOAM RUBBER
 FUTON
 INNER SPRING
 WATERBED
 OTHER _____

ANIMALS & PETS

BIRD
 CAT
 DOG
 GUINEA PIG
 HAMSTER
 HORSE
 RABBIT
 OTHER _____

BLANKETS

COTTON
 QUILT
 SYNTHETIC
 WOOL
 OTHER _____

PLANTS

HAVE IND OOR
 FLOWERING
 HOW MANY? _____

DRUG/MEDICATION HISTORY

ACETAMINOPHEN	CODEINE	NOSE DROPS
ADRENALIN	CORTISONE	PAREGORIC
ANTACIDS	COUGH MEDICINE	PHENOBARBITOL
ANTIBIOTICS	DEMEROL	SLEEPING PILLS
ANTIHIISTAMINES	DIGITALIS	SULFA DRUGS
ASPIRIN	DILANTIN	TRANQUILIZERS
BIRTH CONTROL PILLS	HORMONES	OTHER _____
BLOOD PRESSURE	INSULIN	_____
MEDICINE	LAXATIVES	_____

LIST ANY OTHER DRUGS OR MEDICATIONS OR ANTIBIOTICS THAT CAUSE A REACTION: _____

HAVE YOU REACTED TO:

DENTAL ANESTHETICS	TETANUS ANTITOXINS
IODIDES	TETANUS TOXOID
	X-RAY CONTRAST MEDIA

DO YOU REQUIRE ADJUSTED DOSES OF MEDICATIONS? (CIRCLE ONE) YES NO

SUPPLEMENT HISTORY

ELECTROLYTES	VITAMINS
IRON	OTHER _____
MINERALS	_____

LIST SUPPLEMENTS YOU TAKE REGULARLY OR OCCASIONALLY: _____

MEDICAL HEALTH HISTORY

FOOD HISTORY

WHICH OF THE FOLLOWING HAVE YOU EXPERIENCED?

- AVOID CERTAIN FOODS
- BOTHERED BY FOOD ODOR
- CAVEMAN DIETS
- COOK FROM SCRATCH
- CRAVE BEVERAGES
- CRAVE CERTAIN FOODS
- DISLIKE CERTAIN FOODS
- EAT DAYTIME SNACKS
- EAT JUNK FOODS
- EAT REGULAR MEALS
- ELIMINATION DIETS
- EXCESSIVE HUNGER
- EXCESSIVE THIRST
- HAVE BEDTIME SNACKS
- ROTATION DIETS
- SKIP MEALS ON REGULAR BASIS
- USE CONVENIENCE FOODS
- USE EXOTIC FOODS
- WEIGHT GAIN
- WEIGHT LOSS

OTHER _____

HAVE YOU EVEN BEEN ON A SPECIAL DIET? **Yes** **NO**

WHAT KIND? _____

WHAT KIND OF FOODS DO YOU CRAVE? _____

WHAT KIND OF FOODS DO YOU DISLIKE? _____

DO YOU EAT FOODS THAT ARE

- CANNED
- FRESH
- FROZEN
- PREPACKAGED

DO YOU EAT MOST OF YOUR MEALS:

- HOME
- RESTAURANTS

WHAT HAPPENS IF YOU MISS A MEAL?

IS THERE A FAMILY HISTORY OF ALLERGIES OR FOOD INTOLERANCE?

YES NO

IF YES, EXPLAIN _____

MEDICAL HEALTH HISTORY

___ DUCK	___ HONEYDEW MELON	___ PEANUT OIL
___ EGG	___ PERSIAN MELON	___ PEAR
___ EGGPLANT	___ WATERMELON	___ PECAN
___ ENDIVE	___ MILK (COW)	___ PEPPER
___ FIG	___ MILK (GOAT)	___ PEPPERMINT
___ GARLIC	___ MOLASSES	___ PIE/CREAM
___ GELATIN	___ MUNG BEAN	___ PIE/FRUIT
___ GINGER	___ MUSHROOMS	___ PIMENTO
___ GRAPEFRUIT	___ MUSTARD	___ PINEAPPLE
___ GRAPES	___ MUSTARD GREENS	___ PISTACHIO
___ HAZELNUT	___ NUTMEG	___ PLUM
___ HONEY	___ OATS	___ POPPY SEED
___ HOPS	___ OKRA	___ PORK
___ HORSERADISH	___ OLIVE	___ POTATO (SWEET)
___ ICE CREAM	___ OLIVE OIL	___ POTATO (WHITE)
___ JAM/JELLY	___ ONION	___ PROCESSED FOODS
___ LAMB	___ ORANGE	___ PRUNE
___ LEMON	___ POTATO CHIPS	___ PUMPKIN SEED
___ LENTIL	___ OREGANO	___ RAISIN
___ LETTUCE	___ PAPAYA	___ RABBIT
___ LICORICE	___ PAPRIKA	___ RADISH
___ LIME	___ PARMESAN CHEESE	___ RICE
___ MANGO	___ PARSLEY	___ ROQUEFORT
___ MAPLE SYRUP	___ PARSNIP	___ RYE
___ MAYONNAISE	___ PEAS	___ SACCHARIN
___ CANTALOUPE	___ PEACH	___ SAFFLOWER OIL
___ CASABA MELON	___ PEANUT	___ SAGE

MEDICAL HEALTH HISTORY

EATING PATTERN

PLEASE LIST THE FOODS YOU NORMALLY CONSUME ON A TYPICAL DAY.
INCLUDE SNACKS, BEVERAGES, ETC.

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

SUPPLEMENTS TAKEN:

OTHER:
