NATIONAL UNIVERSITY OF HEALTH CENTERS Natural Medicine

PERSONAL HEALTH HISTORY

Patient: _____ _____ _____ Date of Birth _____
Last Name First Name Middle Name

What is the main reason for your visit to our clinic today?

_____

Allergies: Do you have any allergies to the following? **(Please select all that apply)**

☐ Sulfa ☐ Penicillin ☐ Tetracycline ☐ Morphine ☐ Aspirin ☐ Codeine
☐ NSAIDS ☐ Latex ☐ Lidocaine ☐ Contrast Dye ☐ Sulfites ☐ Pollen
☐ Cats ☐ Dogs ☐ Mold ☐ Dust ☐ Bees ☐ Soy
☐ Wheat ☐ Shellfish ☐ Fish ☐ Peanuts ☐ Eggs ☐ Milk
☐ Other _____

Medications: List all medications, over-the-counter medications, vitamins, or other supplements you are taking:

Name of Medication/Supplement	Strength	Frequency Taken

Medical Conditions: Do you currently have or have a history of the following? **(Please select all that apply)**

☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Stroke
☐ Asthma ☐ COPD ☐ Diabetes ☐ Cancer
☐ Depression/Anxiety ☐ Liver Disease ☐ Digestive Problems ☐ Thyroid Disorder
☐ Adrenal Disorder ☐ Kidney Disease

Surgeries / Hospitalizations: Have you had any of the following surgeries? **(Please select all that apply)**

☐ Appendectomy ☐ Brain Surgery ☐ Breast Surgery ☐ C-Section
☐ CABG ☐ Cholecystectomy ☐ Colon Surgery ☐ Cosmetic
☐ Eye Surgery ☐ Fracture Surgery ☐ Hernia Repair ☐ Hysterectomy
☐ Joint Replacement ☐ Prostate Surgery ☐ Small Intestine Surgery ☐ Spine Surgery
☐ Tonsillectomy ☐ Tubal Ligation ☐ Valve Replacement ☐ Vasectomy
☐ Other: _____

Family History: Do you have a family history of any of the following? (**Please "X" the boxes that apply to you**)

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcohol/ Drug Addiction												
Arthritis												
Asthma												
Cancer												
Heart Disease												
Depression												
Diabetes												
High Cholesterol												
High Blood Pressure												
Kidney Disease												
Mental Illness												
Stroke												
Vision Problems												

Continue to pages 3 & 4 →

Social History: Please answer the following questions regarding your social history:

Do you drink alcohol?	☐ Yes	☐ No

If "YES", how many of the following per week: _____glasses of wine _____shots of liquor _____cans of beer

Are you sexually active?	☐ Yes	☐ No	☐ Not Currently
Partners?	☐ Male	☐ Female	☐ Both

What is your current birth control method? (Please check all that apply):

☐ Abstinence ☐ Cervical Cap ☐ Condom ☐ Diaphragm ☐ Hormone Patch ☐ Implant
☐ Injection ☐ Inserts ☐ IUD ☐ IUS ☐ Pill ☐ Rhythm
☐ Spermicide ☐ Sponge ☐ Surgical ☐ Vaginal Ring ☐ Withdrawal ☐ None

Do you currently use any of the following recreational or street drugs? (Please select all that apply):

☐ Crack ☐ Cocaine ☐ Ecstacy ☐ IV ☐ Heroin ☐ LSD
☐ Marijuana ☐ Meth ☐ E-Cigs ☐ Other _____

Do you use any of the following tobacco products? (Please select all that apply):

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Snuff ☐ Chew
☐ Other _____ Packs per day: _____
Start Date: _____ Years of smoking: _____
Quit Date: _____ Ready to Quit? ☐ Yes ☐ No

Review of Systems: **Please circle below: Y= Yes, present condition. N=No, never had the condition.**

Constitutional

Fever	Y N	Chills	Y N	Weight Loss	Y N
Malaise/Fatigue	Y N	Sweating	Y N	Weakness	Y N

Skin

Rash	Y N	Itching	Y N	Color changes	Y N

Head, Ears, Eyes, Nose, Throat

Headaches	Y N	Hearing Loss	Y N	Ringing in Ears	Y N
Ear Pain	Y N	Ear Discharge	Y N	Nosebleeds	Y N
Congestion	Y N	Stridor	Y N	Sore Throat	Y N
Migraine headaches	Y N	Jaw/TMJ problems	Y N		

Eyes

Blurred Vision	Y N	Double Vision	Y N	Light Sensitivity	Y N
Eye Pain	Y N	Eye Discharge	Y N	Eye Redness	Y N

Cardiovascular

Chest Pain	Y N	Palpitations	Y N	Shortness of breath lying down	Y N
Claudication	Y N	Leg Swelling	Y N	PND	Y N
Abdominal Pain	Y N	Blood clots	Y N	Heart disease	Y N
Low/high blood pressure	Y N				

Respiratory

Cough	Y N	Coughing up Blood	Y N	Sputum Production	Y N
Shortness of breath	Y N	Wheezing	Y N		
Asthma	Y N				

Gastrointestinal

Heartburn	Y N	Nausea	Y N	Vomiting	Y N
Abdominal Pain	Y N	Diarrhea	Y N	Constipation	Y N
Blood in Stool	Y N	Black/Tarry Stools	Y N		

How many bowel movements per day? _____

Genitourinary

Painful Urination	Y N	Urgency	Y N	Frequency	Y N
Blood in urine	Y N	Flank Pain	Y N	Incontinence	Y N
Frequent infections	Y N				

Male Reproductive

Hernias	Y N	Testicular masses	Y N	Sexual difficulty	Y N

Female Reproductive

Age of first menses _____ Age of last menses (if menopausal) _____ Length of cycle _____
Duration of menses _____ Date of last annual exam _____ Number of pregnancies _____
Number of live births _____ Number of miscarriages _____ Number of abortions _____

Musculoskeletal

Muscle Pain	Y N	Neck Pain	Y N	Back Pain	Y N
Joint pain	Y N	Falls	Y N	Muscle spasms	Y N

Endocrine/Heme/Allergies

Excessive thirst	Y N	Env. Allergies	Y N	Easy Bruising/Bleeding	Y N
Cold intolerance	Y N	Excessive hunger	Y N	Heat intolerance	Y N

Diabetes _____ Thyroid problems_____

Neurological

Dizziness	Y N	Tingling	Y N	Tremor	Y N
Sensory Change	Y N	Speech Change	Y N	Focal Weakness	Y N
Seizures	Y N	Fainting	Y N	Numbness	Y N
Paralysis	Y N	Loss of memory	Y N		

Emotional (Psychiatric)

Depression	Y N	Suicidal Ideas	Y N	Substance Abuse	Y N
Hallucinations	Y N	Nervous/Anxious	Y N	Insomnia	Y N
Memory Loss	Y N	Mood swings	Y N	Tension/stressed	Y N