Health Evaluation

This health evaluation is designed for you and members of your health care team with whom you wish to share it. Answering the questions as thoroughly as possible will provide insight into your current health status. Pulling all this information together helps one to see patterns and tendencies. The information is confidential and will not be released to any person without your request.

Date:_____

Name:_____**Age:**_____**DOB:**_____

Address:_____

Home Phone:_____**Work Phone:**_____

Height:_____**Weight:**_____**1 Year Ago:**_____**5 Years Ago:**_____

Occupation:_____**Full Time:**_____**or Part Time:**_____

Living Situation:

- ☐ Alone
- ☐ Friends
- ☐ Partner
- ☐ Spouse
- ☐ Parents
- ☐ Children
- ☐ Pets

Names and ages of those living with you:_____

_____

What are your major health concerns and intentions for your visit today?

_____

_____

Please list any other health care providers or consultants you are currently working with:

_____

_____

Would you like any of them to receive a copy of your recommendations?_____

Please list all herbs, vitamins, and dietary supplements you are currently taking, citing brand name whenever possible (use additional space on back if needed):

Product	Dosage	Frequency (#/day)

List all medications you are currently taking (including aspirin, antacids, etc.) indicating whether they are over the counter (OTC) or Prescribed (P). Use additional space on back if needed.

Product	OTC or P?	Dosage	Frequency (#/day)

List all medications, herbs, etc., to which you have a known allergy:

DIETARY INFORMATION

Describe below your typical meals. Please be as specific as possible. For example, instead of “oil” list type of oil, such as olive, corn, etc. Instead of “bread” list whether white or whole grain, etc. Instead of “vegetables” list the type of vegetable, how prepared, canned, frozen, or fresh, etc. Please include all beverages, type and quantity (two cups of coffee, one glass of orange juice, etc.)

Breakfast:_____

_____

Morning snack(s):_____

Lunch:_____

_____

Afternoon snack(s):_____

Dinner:_____

_____

Daily water consumption (# of glasses/day):_____

Any recurring food cravings (such as salt, starch, sugar, chocolate, etc.):

_____

Please list any known food allergies/sensitivities:

Food	**Describe reaction**
_____	
_____	

FAMILY HISTORY

Please describe any relevant or major health related issues (alcoholism, high blood pressure, cancer, diabetes, heart disease, psychiatric illness, osteoporosis, other addictions, other illnesses):

Mother:_____

Father:_____

Sister(s):_____

Brother(s):_____

Maternal Grandmother:_____

Maternal Grandfather:_____

Paternal Grandmother:_____

Paternal Grandfather:_____

Other family members with pertinent issues, or recurring family health trends:_____
_____
_____

PAST HEALTH PROBLEMS

List all major health problems including any operations:

Problem	**Year**

GENERAL HEALTH

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain in heart
- ☐ Poor circulation
- ☐ Swelling
- ☐ Stroke/murmur

Skin

- ☐ Boils
- ☐ Bruises
- ☐ Dryness
- ☐ Itching
- ☐ Varicose veins
- ☐ Skin eruptions

Muscles/Joints

- ☐ Backache
- ☐ Broken Bones
- ☐ Mobility
- ☐ Arthritis
- ☐ Bursitis
- ☐ Weakness

Respiratory

- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Cough
- ☐ Tuberculosis
- ☐ Congestion
- ☐ Wheezing
- ☐ Asthma
- ☐ Coughing up blood

Urinary/Kidney

- ☐ Excessive urination
- ☐ Water retention
- ☐ Burning urine
- ☐ Kidney stones
- ☐ Lower back pain
- ☐ Dark circles/under eyes
- ☐ Itchy ears/eyes
- ☐ Blood in urine

Gastro-Intestinal

- ☐ Belching
- ☐ Colitis
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Liver problems
- ☐ Gall stones
- ☐ Ulcers
- ☐ Transit time

Eyes, Ears, Nose and Throat

- ☐ Failing vision
- ☐ Sinus congestion
- ☐ Sore throat
- ☐ Canker sores
- ☐ Ear aches
- ☐ Hay fever
- ☐ Tonsils
- ☐ Nose bleeds
- ☐ Eye pains
- ☐ Sinus infection
- ☐ Hearing loss

General

- ☐ Fatigue
- ☐ Night sweats
- ☐ Fever
- ☐ Excessive thirst
- ☐ Loss of appetite
- ☐ Always hungry
- ☐ Difficulty sleeping
- ☐ Frequently colder or warmer than others

Male Reproductive

- ☐ Burning/discharge
- ☐ Lumps/swelling of testicles
- ☐ Painful testicles
- ☐ Vasectomy

Female Reproductive

- ☐ Age of first period
- ☐ Regular
- ☐ Length of cycle
- ☐ Heavy bleeding
- ☐ Clots
- ☐ Pains/cramps
- ☐ Vaginal discharge
- ☐ Color/amount
- ☐ Vaginal itching
- ☐ Painful intercourse
- ☐ Cervical dysplasia
- ☐ Pelvic pain
- ☐ Breast pain
- ☐ Breast lump
- ☐ Anemia
- ☐ Infertility
- ☐ Genital herpes
- ☐ Hot flashes
- ☐ Mood swings
- ☐ Dry vaginal lining
- ☐ Osteoporosis

Contraceptive/Pregnancy History

- ☐ BC Pills
- ☐ Rhythm
- ☐ IUD
- ☐ Diaphragm
- ☐ Condoms
- ☐ Mucous method
- ☐ Cervical cap
- ☐ Spermicides
- ☐ Fertility lens

Please list each pregnancy you have had, including miscarriages and abortions:

_____

_____

CURRENT STATE OF EMOTIONS AND SPIRITUAL WELL-BEING

Take time to think about and answer the following questions:

Are you completely satisfied with your living conditions?

Are you able to express your feelings and emotions?

Is there an excess of stress in your life? What is causing the stress?

Are you satisfied with your job?

If in a relationship, are you satisfied with it? Are you lonely?

Is there something you would like to change in your life? Can you change it?

Are you a "nervous type" of person? What type of things make you nervous?

Do you sleep well? How many hours (in a 24-hour period)?

Do you dream? Do you remember your dreams?

Are you satisfied with your energy level? Do you often feel exhausted?

Is it easy to wake up in the morning?

Do you enjoy your work?

Do you have hobbies/activities you enjoy outside of work?

Which of these feelings dominate your life?

Joy ☐ Happiness ☐ Anger ☐ Sadness ☐ Fear ☐ Sympathy ☐ Worry ☐ Depression ☐ Other ☐

Do you believe in a higher power? Are you at peace with this belief/relationship?

Please list approximate dates and describe the nature of any traumatic experiences you have had in the past 7 years (divorce, loss of lover, loss of job, change of residence, injury, death of a loved one, etc.)

Year **Event**

_____

_____

_____

LIFESTYLE HABITS

Routine physical exercise: Type of exercise_____

For how many minutes?_____How often?_____

Tobacco use: How much?_____How often?_____

Alcohol use: How much?_____How often?_____

Caffeine use: How much?_____How often?_____

Mood altering substances (such as cocaine, marijuana, etc.)

How much?_____How often?_____

How many hours of television do you watch in a week?_____

Please use this space to add any other information about yourself that you think will be helpful:

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Please send completed form to
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