On Wellness Clinic
Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally & emotionally. Please complete this questionnaire as thoroughly as possible. Indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to the On Wellness Clinic in order of importance below:

Condition **Past Treatment**

a. _____ _____

How does this condition affect you? _____

b. _____ _____

How does this condition affect you? _____

c. _____ _____

How does this condition affect you? _____

d. _____ _____

How does this condition affect you? _____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. **Family History:**	Father	Mother	Brothers	Sisters	Spouse	Children
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	_____	_____	_____	_____	_____	_____

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

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

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B Others: _____

13. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

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

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

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

Mood Swings Nervousness Mental Tension

16. **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

17. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now & underline any that you have 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

18. **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: _____

19. **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

20. **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

21. **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

22. **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

23. **Menstrual/Birthing History**:

1. Age of First Menses: _____ 2. # of Days of Menses: _____ 3. Length of Cycle: _____

4. Birth Control Type: _____ 5. # of Pregnancies: _____ 6. # of Miscarriages: _____

If previous pregnancies:

Dates (best approximate):	Outcome:	Known complications:	If live birth, delivery type:
_____	Miscarriage / Abortion / Live birth	_____	Vaginal C-section
_____	Miscarriage / Abortion / Live birth	_____	Vaginal C-section
_____	Miscarriage / Abortion / Live birth	_____	Vaginal C-section

24. **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

If infertility issues, have you ever achieved pregnancy? Y N If yes: Current partner Previous partner Dates: _____

25. **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?): _____

26. **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

27. **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

28. **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? _____

_____

29. **Lifestyle:**

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

b. Typical diet: _____

c. Exercise routine: _____

d. Spiritual practice: _____

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

f. Level of education completed: High School BachelorsMasters Doctorate Other

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

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

h. Nicotine/Alcohol/Caffeine Use: _____

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

_____

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

k. Television habits: _____ Reading habits: _____

l. Interests and hobbies: _____

How did you hear about us? _____

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