Confidential Patient Health Record

1. Please enter your information.

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

Gender: ◉ Female ○ Male Age: _____ Marital Status: _____ How many children? _____

Name of spouse: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Would you like to receive our Newsletter? ◉ Yes ○ No

Other nearest relative: _____ Phone: _____

Who referred you to this office? _____

2. If patient is a minor, I hereby give my consent and permission to treat:

Child's name: _____ Date: _____ Relationship to patient: _____

Signature of Parent of Guardian

_____ _____

Signature Date

3. Please describe your major health concerns:

	List here
1	
2	
3	

4. If you feel ill, when did you last feel well?

5. What goals would you like to achieve while you are in our office? BE SPECIFIC! (I.e. not "better health," but "weight loss," "more energy" etc...).

	List here
1	
2	
3	

6. Pertaining to the goals listed, what would you be willing to do, to achieve them:

7. Where did you grow up?

Have you traveled outside the US, including Mexico & Canada?

○ Yes ◉ No

8. How many times?

	Place of trip	Date of trip	How long on the trip	Did you become ill?	During or After?	Medication taken
1						
2						
3						

9. Have you ever had parasites that you are aware of?

○ Yes ○ No

10. If yes, what was done to resolve?

11. Have you ever had food poisoning?

○ Yes ○ No

12. If yes, how resolved?

13. How many bowel movements do you have per day?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ Formed
- ☐ Loose

14. Approximately how many times have you used antibiotics from childhood to the present?

- ○ 0
- ○ 1 – 5 times
- ○ 6 – 10 times
- ○ More than 10

15. Any long-term use? (E.g. acne, prolonged illness or use in a hospital))

○ Yes ○ No

16. What was the reason for the long-term use of antibiotics?

_____

17. Have you used or are your using prescription medications?

○ Yes ○ No

18. Please list the prescription medications that you have taken:

	Name of Drug	Reason for taking	Start and end date taken	Still taking?	Side affects that you know of?
1					
2					
3					

19. Do you use Tylenol, Ibuprofen, aspirin or other pain medications?

○ Yes ○ No

20. Have you used them in the past?

○ Yes ○ No

21.

Name of Medication	How often do you take it?	How much do you take when you take it?
Tylenol		
Ibuprofen		
Aspirin		
Motrin		

22. Do you drink or did you drink in the past: diet soda or use artificial sweeteners?

○ Yes ○ No

23.

	Name of Beverage/sweetener	Are you still drinking diet beverages or using artificial sweeteners?	ow many an average month?
1			
2			
3			

24. Do you have mold allergies/exposure that you know of?

○ Yes ○ No

25. Do you have any chronic or recurring concerns that never fully go away?

○ Yes ○ No

26.

	What is your concern(s)?	How long have you had this concern?	Why is it a concern for you?	Have you consulted anyone about your concern?
1				
2				
3				

27. Hormone use: Do you use any of the following:

Name of Hormone	If you stopped how long did your take it?	If you are taking it how long have you been taking it?	Any side affects that you know of?
Cortisone			
Prednixone			
Thyroid			
Progesterone			
Estrogen			
Birth Control Pills			

28. Vaccinations/flu shots: Did you have any of the following:

Name of Vaccination	Date(s) that you had it?	Any reactions that you know of	Did you get sick after the vaccination?	How long after the vaccination did you get sick?
Flu shot				
Polio				
DPT				
Tetanus				
Hepatitis B				
MMR				

29. Teeth

Do you have any fillings? ○ Yes ○ No

Approximately how many? _____

What materials were used? ○ Silver/Mercury ○ Gold ○ Plastic ○ Porcelain

Do you have any root canal(s)? ○ Yes ○ No

Approximately how many? _____

Do you have any crown(s)? ○ Yes ○ No

Approximately how many? _____

What materials were used? ○ Gold ○ Porcelain

Do you have any tooth sensitivities? ○ Yes ○ No

If yes: ○ Cold ○ Hot ○ Touch

30. Sleep/Energy

	Yes	No
Do you have energy throughout your day?	◯	◯
Do you need coffee, tea or other caffeinated beverage to keep you going?	◯	◯
Do you need to sleep more than eight hours a night?	◯	◯

31. I wake up: ◯ Refreshed ◯ Tired

General mood: _____

This is attributed to _____

32. Pesticides/chemicals:

	Yes	No
Have you had exposure to pesticides?		
Do you use pesticide strips?		
Do you spray for insects with Raid or a similar product?		
Do you have or have you had a termite problem?		
Have you sprayed for termites?		
Did you grow up near or on a farm?		
Have you lived near a public school or park?		
Do you live near a public school or park now?		

33. Were you exposed to pesticides during your childhood?

○ Yes ○ No

34. If YES, please describe the circumstances of your exposure:

_____

35. Does your work expose you to chemicals? (E.g. paints, glues, white-out, copying, etc...)

○ Yes ○ No

36. Do you use many products containing chemicals in your home?

○ Yes ○ No

37. Do you have chemical sensitivities?

○ Yes ○ No

38. If yes, please describe:

_____

39. Do you color your hair? if yes, how often?

_____

40. Do you have any tattoos?

○ Yes ○ No

41. How long have you had them? _____ How many? _____ Where on your body? _____

42. Have you remodeled your home in the last 5 /10/15 years?

○ Yes ○ No

43. Has new carpeting been put in your home? When?

○ Yes ○ No

Painting done? New furniture? When?

○ Yes ○ No

44.

	YES	NO
Electromagnetic/ EMF: Do you live near high power lines?		
Do you work near them?		
Do you live/work near microwave antennas?		
Do you use florescent lights in your home/work?		
Does the computer have a flat screen monitor?		
Do you use an electric blanket?		
Do you use a hair dryer?		
Do you sleep with an alarm clock within 3 feet of your head?		

How many hours per day do you spend at a computer?

45. For Women only:

Have you ever taken birth control pills? How long?

○ Yes ○ No

Are you currently using birth control pills? What kind?

○ Yes ○ No

What side effects (if you know of any) did you experience from taking birth control pills?

46. Are you doing Hormone Replacement Therapy or did you do it in the past?

○ Yes ○ No

47. What kind of HRT? How long have you been doing it or did you do it?

If you stopped doing it, when did you stop? Length of cycle in days? Other:

Are you presently prone to yeast infections? Were you in the past?

○ Yes ○ No ○ Yes ○ No

Menstrual period: How many days? Fibrocystic breast tissue?

○ Heavy ○ Light ○ Yes ○ No

48. Have you had a mammogram?

○ Yes ○ No

49. What was the date of your last mammogram?

Where did you have it done? (hospital, clinic etc...)

How often do you have them?

50. Have you had a breast thermography?

○ Yes ○ No

51. What was the date of your last thermography?

Where did you have it done? (hospital, clinic etc...)

How often do you have them?

52. Uterine Fibroids?

○ Yes ○ No

53. Check any of the following symptoms that you experience before during or after your period:

	BEFORE	DURING	AFTER
Cramps			
Bloating			
Back pain			
Headache			
Swelling			
Emotional changes			
Bowel changes			
Sleeping difficulties			
Fatigue			

54.

	Yes	No
Are all your body parts your own?		
Knee/Hip replacement?		
Metal/Surgical implants?		
Transplants?		

55. Name: _____ DOB: _____ Gender: ○ Male ○ Female

56. Have you suffered from: E.E.N.T

	Past	Current
vision problems (far sighted- ness, near sightedness)		
blurred vision		
dry, itchy eyes		
styes		
cataracts		
glaucoma		
night blindness		
conjuctivitus		
crossed eyes		
nose bleeds		
nasal obstruction		
sinus trouble		
loss of smell		
hoarseness		
sore throat		
tonsilitis		
swollen glands		
enlarged thyroid (goiter)		
difficult swallowing		
bad taste in mouth		
metallic taste in mouth		
loss of taste		
gag easily		
dry mouth		

always thirsty		
canker sores		
sore tongue		
cracks at corners of mouth		
chapped lps		
earaches		
pressure in ears		
ringing/buzzing in ears		
hearing loss		
ear discharge		

57. Gastro-Intestinal

	Past	Current
belching		
heartburn		
gas		
colitis		
constipation		
diarrhea		
hard dry stool		
loose stool		
mucous in stool		
blood in stool		
gastritis		
ulcers		
nervous stomach		
irritable bowel		
hemorrhoids (piles)		
rectum itches		
vomiting		
nausea		
loss of appetite		
upset by greasy foods		
abdominal pain		
stomach pain		
distention of abdomen		

58. Cardio-vascular respiratory

	Past	Current
high blood pressure		
low blood pressure		
chest pain		
angina		
shortness of breath		
poor circulation		
persistent cough		
wheezing		
asthma		
difficult breathing		
rapid heart beat		
slow heart beat		
previous heart attack		
hardening of the arteries		
spitting up blood		
spitting up phlegm		
allergies		

59. Genito-urinary

	Past	Current
frequent urination		
painful urination		
blood in urine		
bladder infectious		
kidney infections		
kidney stones		
loss of bladder control		
bed wetting		
prostate trouble		
awaken from sleep to urinate		
impotence		
swelling of testicles		
varicocele		
hydrocele		
hernia		

60. Muscle & Joint

	Past	Current
neck pain		
stiff pain		
pain between shoulder blades		
low back pain		
painful tail bone		
swollen joints		
arthritis		
faulty posture		
pain in arms		
pain in legs		
numb hands or feet		
leg cramps		
foot trouble		
burning feet		
less give out		
knees give out		
shoulder pain		
knee pain		
hip pain		
weak ankles		
cracking joints		
bursitis		
twitching muscles		
sciatica		

61. For Women Only

	Past	Current
lumps in breasts		
painful intercourse		
vaginal discharge		
painful menstruation		
excessive flow		
fibroids		
infertility		
loss of libido (desire for sex)		
ovarian cysts		
hot flashes		
irregular cycle		
light or scanty flow		
tipped uterus		

62. General

	Past	Current
headaches		
migraines		
dizziness		
fainting spells		
anxiety - depression		
cold extremities (hands and feet)		
fatigue		
fever		
insomnia		
loss or gain of weight		
numbness		
swelling		
facial pain		
paralysis		
always sick		
frequent infections		
varicose veins		
convulsions		
liver trouble		
jaundice		
poor equilibrium (balance)		

63. Skin, Hair, Nails

	Past	Current
acne		
dry skin		
skin itches		
oily skin		
hives		
excessive perspiration		
boils		
bruise easily		
skin eruptions (rash, psoriasis)		
dandruff		
hair falls out easily		
brittle nails		
soft nails		