Healing Spirit Integrative Health Center
Medical History Form

Date: _____ Patient Name: _____ Date of Birth: _____

Other Physicians involved in my care/Primary Care Physician: _____

Referred to this office by: _____

PREVENTATIVE HEALTH STATUS:

Date of last physical exam: _____ Last eye exam: _____ Last dental exam: _____

Have you ever had a colonoscopy? □ yes □ no When/Findings: _____

Have you ever had a bone density test? □ yes □ no When/Findings: _____

Do you have an Advance Directive for health care decisions? □ yes □ no

SOCIAL HISTORY:

Employment Status: _____ Occupation: _____

Marital Status: □ Single □ Married □ Domestic Partnership □ Divorced □ Widowed

Living Situation: □ Alone □ Roommate □ Spouse □ Parents □ Significant Other □ With Children

Have you been in a relationship where you were hurt, threatened or made to feel afraid? □ yes □ no

Do you feel safe in your home? □ yes □ no

Do you drink alcohol? □ yes □ no How many per week? _____ Quit/When _____

Do you use tobacco? □ yes □ no How much/how long? _____ Quit/When _____

Do you drink caffine? □ yes □ no How much per day? _____

Do you use drugs? □ yes □ no Which ones? _____ Quit/When _____

Do you exercise? □ yes □ no Type: _____ How often? _____

Do you follow a diet? □ yes □ no Please describe: _____

On a scale of 1-10, how satisfied are you with: (10 being the most, 1 being the least) _____ Home _____ Work _____ Relationships

Please **circle** how you would grade your current health: POOR FAIR GOOD EXCELLENT

SEXUAL HISTORY

Sexually Active □ yes □ no Current sexual partner(s) □ male □ female Monogamous Relationship □ yes □ no

Have you ever had a STD? □ yes □ no If yes, which one(s): _____

OFFICE USE ONLY

Updated in OA (date and initials): _____ Scanned (date and initials): _____

Healing Spirit Integrative Health Center
Medical History Form

Today's Date: _____ Patient Name: _____ Date of Birth: _____

PERSONAL MEDICAL HISTORY: Have you ever been diagnosed with the following?

Respiratory:

□ asthma

□ allergies / hay fever

□ chronic bronchitis

□ pneumonia

□ sleep apnea

Gastrointestinal:

□ ulcers

□ colon polyps

□ irritable bowel syndrome

Cancer

□ breast cancer

□ cervical cancer

□ ovarian cancer

□ colon cancer

□ skin cancer

□ prostate cancer

□ other cancer (type)

_____

Heart Disease:

□ murmur

□ angina / coronary disease

□ congestive heart failure

□ irregular heartbeat

□ heart attack

□ high blood pressure

Infectious Disease:

□ AIDS or HIV positive

□ MRSA infection

□ tuberculosis

Musculoskeletal

□ rheumatiod arthritis

□ lymphedema

□ osteoarthritis

□ osteoporosis

Gynecological

□ abnormal PAP

□ ovarian cysts / tumors

□ irregular bleeding

Mental Health / Nurologic:

□ anxiety

□ depression

□ alcoholsim

□ drug abuse

□ other mental illness

□ migraines / headaches

□ stroke

□ seizures / epilepsy

Metabolic / Nutrition

□ diabetes

□ high cholesterol

□ anemia

□ thyroid problems

□ blood clots

□ bleeding disorder

Kidney / Bladder

□ stones

□ incontinence

□ urinary tract infection

Hospitalizations, operations, serious illnesses or injuries: (give approximate date)

1. _____
2. _____
3. _____
4. _____

Present Medications: (include birth control pills and non-prescriptive items such as vitamins, aspirin, herbs, etc.)

Name	Dose	Times/Day	Name	Dose	Times/Day
1.			3.		
2.			4.		

Drug allergies: _____ Food/Other allergies: _____

Preferred Pharmacy: _____

Healing Spirit Integrative Health Center
Medical History Form

Today's Date: _____ Patient Name: _____ Date of Birth: _____

FAMILY HISTORY: Has any of your immediate family ever had: (if yes, indicate relationship and age of onset)

Alcohol/Substance Abuse	High Cholesterol
Blood Clots	Lung Disease
Cancer	Lymphedema
Diabetes	Mental Illness
Epilepsy/Seizures	Osteoporosis
Heart Disease	Stroke
High Blood Pressure	Other

REVIEW OF SYMPTOMS: Check any of the following symptoms you have experienced WITHIN THE PAST YEAR

□ Bowel problems
□ Chest pains
□ Coordination problems
□ Cough
□ Difficulty sleeping
□ Difficulty swallowing
□ Difficulty walking
□ Dizziness or blackouts
□ Ear problems
□ Eye problems
□ Fever / chills / sweats
□ Head injury
□ Headaches / migraines
□ Hearing problems
□ Heart problems
□ Hoarseness
□ Joint pain / swelling
□ Loss of appetite
□ Loss of balance
□ Pain in arms / legs
□ Shortness of breath
□ Skin irritation / infection
□ Urinary problems
□ Vision problems
□ Weakness in arms / legs
□ Weight loss / gain
□ Other _____
□ **None of the above**

For Women Only

□ Heavy menstrual bleeding
□ Irregular menstrual periods
□ Itching, burning or discharge
□ Cramps
□ Hot flashes
□ Painful intercourse
□ Pelvic inflammatory disease (PID)

FOR WOMEN ONLY

Date of last period: _____ Age periods began: _____ Age at start of menopause: _____

Cycle REGULAR/IRREGULAR every _____ days with flow for _____ days. Have you received the Gardasil Vaccine? YES / NO

Have you had a PAP? YES / NO Have you had a mammogram? YES / NO Have you had a breast biopsy? YES / NO

Last Date/ Result: _____ Last Date/ Result: _____ Last Date/ Result: _____

Do you use condoms? □ yes □ no Current contraceptive method: _____

Number of pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____ Cesarean Sections: _____

Problems during pregnancies: _____