Patient Health History

Name: ______________________________ Date: ______________

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, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Height: __________ Current Weight: __________ Past Maximum Weight: When?

Pulse: __________ Blood Pressure: __________ Other: ______________________

1. Please identify the health concerns that have brought you to ICAM 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? ______________________

2. Please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction).

____

____

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

____

____

4. Do you have any reason to believe you may be pregnant? Y N If yes, how far along are you? __________

5. Do you have any infectious diseases? Y N If yes, please specify: ______________________

6. **FAMILY HISTORY (Check those applicable):**

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Health (G = good, P= poor)						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						
Asthma/Hay Fever						
Kidney Disease						
Age (at death)						
Cause of Death						

7. **Childhood Illnesses** (please circle any that you have had):

Scarlet Fever Rheumatic Fever Mumps Measles German Measles Chicken Pox

8. **Hospitalizations and Surgeries:**

Reason **When**

____

____

____

____

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

Mood Swings Nervousness Mental Tension

10. **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**

11. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced 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 Problems	Hay Fever

12. **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: ______________________		

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

Heart Disease	Chest Pain	Swelling Ankles	High Blood Pressure	Palpitations/Fluttering
Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins	

14. **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			

15. **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	

16. **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				

17. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties	Prostate Problems	Testicular Pain/Swelling	Penile Discharge

18. **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	Joint Pain (where?)
Mid Back Pain	Low Back Pain	Leg Pain		

19. **Neurological** (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

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

Hypothyroid	Hypoglycemia	Diabetes Mellitus	Night Sweats	Feeling Hot or Cold

21. **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

22. **Lifestyle:**

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

b. Exercise routine: ______________________

c. Spiritual practice:

d. How many hours per night do you sleep? ________ Do you wake rested? Y N

e. Occupation: ____________ Employer: ____________ Hours/Week: ____________

Do you enjoy work? Y N Why/why not? ______________________

f. Nicotine/Alcohol/Caffeine Use: ______________________

g. Have you experienced any major traumas? Y N Explain: ______________________

____

h. How much water do you drink every day? ______________________

i. Do you have a bowel movement every day? Y N

23. **Dental History**

a. Do you have any silver (mercury) fillings? Y N

b. Do you have any root canals? Y N