HEALTH HISTORY

Name: _____ Date: _____

Date of Birth: _____ Name of General Practitioner: _____
May we contact your General Practitioner? Yes/No.

Biometrics:
Height: _____

Weight: _____

Waist circumference:_____

Hip circumference: _____

Chief Complaint: What is your reason for the appointment today? Please be specific.

_____

_____

_____

Past Medical History: Please check all that apply to you.

❑ Arthritis ❑ Cancer ❑ Depression ❑ Diabetes	❑ Epilepsy/seizures ❑ Heart surgery ❑ Heart disease ❑ High blood pressure	❑ Psychiatric Disorder ❑ Stroke ❑ Thyroid ❑ None

Previous Surgeries: Please list all surgeries that you have had with an approximate date.

_____

_____

_____

Previous Injuries: Please describe any serious injuries that you have had with an approximate date.

_____

_____

_____

Medications: Please list any medication that you are taking.

_____

_____

_____

Allergies: Please list any allergies that you have.

_____

_____

Do you drink alcohol? Yes/No. If yes, how much per week? _____

Do you smoke? Yes/No. If yes, how much per day?_____

Do you consume caffeine? Yes/No. If yes, how much per day? _____

Do you use recreational drugs? Yes/No. If Yes, what type and frequency?_____

Are you on a special diet? Yes/No. If yes, please describe.

_____

Family History: Do you know of any blood relative that has or had

❑ Asthma ❑ Aneurysm ❑ Brain Tumor ❑ Cancer, Type: ❑ Diabetes ❑ Seizures/Epilepsy	❑ Headaches ❑ Heart Problems ❑ High Blood Pressure ❑ Kidney Disease ❑ Lung Disease, Type: ❑ Migrain	❑ Multiple Sclerosis ❑ Psychiatric Disorder, Type: ❑ Stroke ❑ Thyroid ❑ None

Comments:

Please review the list below. Check all that you have experienced in the past or are currently experiencing. If you have never experienced any of these, please check none.

General Health ❑ Good general health ❑ Recent weight change ❑ Loss of appetite ❑ Fatigue ❑ Fever/Chills **Allergies** ❑ Food allergies ❑ Drug allergies ❑ Hay fever ❑ Other: ❑ None **Ears, Nose, Mouth, Throat** ❑ Difficulty swallowing ❑ Earaches ❑ Loss of hearing/deafness ❑ Loss of smell ❑ Loss of taste	**Genitourinary** ❑ Blood in urine ❑ Irregular periods ❑ Pregnancy ❑ Miscarriage ❑ Kidney stones ❑ Prostate disease ❑ Testicle pain ❑ Painful urination ❑ Sexual difficulty ❑ Sexually transmitted infection or disease ❑ Urgency with urination ❑ Urine retention/ incontinence ❑ Other: ❑ none **Heart and Lungs** ❑ Pain in chest	❑ Mental confusion ❑ Migraine ❑ Ministroke ❑ Neuropathy ❑ Numbness or tingling ❑ Paralysis ❑ Stroke ❑ Tremors ❑ Weakness ❑ Other: ❑ None **Psychiatric** ❑ Depression ❑ Anxiety ❑ Eating disorder ❑ Other: ❑ None **Pulmonary** ❑ Asthma

- ❏ Painful chewing
- ❏ Ringing in ears
- ❏ Sinus infection
- ❏ Sores in mouth
- ❏ Other:
- ❏ None

Eyes

- ❏ Blind spots
- ❏ Blurred vision
- ❏ Double vision
- ❏ Loss of vision
- ❏ Glaucoma
- ❏ Injury
- ❏ Pain
- ❏ Other:
- ❏ None

Gastrointestinal

- ❏ Blood in stool
- ❏ Constipation
- ❏ Nausea
- ❏ Painful bowel movements
- ❏ Persistent diarrhea
- ❏ Stomach or abdominal pain
- ❏ Ulcer
- ❏ Vomiting
- ❏ Other:
- ❏ None

- ❏ High blood pressure
- ❏ High cholesterol
- ❏ Irregular heartbeat
- ❏ Other:
- ❏ None

Muscles, Joints & Bones

- ❏ Back pain
- ❏ Difficulty walking
- ❏ Joint pain
- ❏ Joint stiffness or swelling
- ❏ Muscle pain or tenderness
- ❏ Neck pain
- ❏ Other:
- ❏ None

Neurological

- ❏ Balance difficulty
- ❏ Loss of consciousness
- ❏ Difficulty speaking
- ❏ Difficulty walking
- ❏ Facial drooping
- ❏ Headaches
- ❏ Injury to brain or spine
- ❏ Light-headed or dizziness
- ❏ Memory loss

- ❏ Blood in cough
- ❏ Cancer
- ❏ Chronic cough
- ❏ Emphysema
- ❏ Pneumonia
- ❏ Shortness of breath
- ❏ Other:
- ❏ None

Skin

- ❏ Redness or itching
- ❏ Sun sensitivity
- ❏ Hair loss
- ❏ Color changes
- ❏ Other:
- ❏ None

Sleep

- ❏ Snoring
- ❏ Sleepwalking
- ❏ Nightmares

Do you sleep well?

- ❏ Yes
- ❏ No

Do you feel rested when you wake?

- ❏ Yes
- ❏ No

Do you fall asleep during the day?

- ❏ Yes
- ❏ No

This information is confidential. No health history information will be shared with anyone outside of ELLO Holistic Health without your consent.

By signing below, I affirm that I have provided an accurate and complete personal health history.

_____ _____

Signature Date MM/DD/YYYY