

# HEALTH HISTORY

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Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Sex \_\_\_\_\_ Number of Children \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widow(er)

Reason for office visit \_\_\_\_\_ Date began \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Practitioner name and phone number \_\_\_\_\_

Laboratory procedures performed (e.g., stool analysis, blood urine chemistries, hair analysis) \_\_\_\_\_

What types of therapy have you tried for this problem(s):

- diet modification  fasting  vitamin/mineral  herbs  homeopathy  chiropractic  acupuncture  conventional drug  
 other \_\_\_\_\_

List current health problems for which you are being treated: \_\_\_\_\_

Current medications (prescription or over-the-counter): \_\_\_\_\_

List any allergies (including medication): \_\_\_\_\_

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Operation, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress in job, work, residence or finances, legal problems): \_\_\_\_\_

Do you consider yourself:  underweight  overweight  just right Your weight today \_\_\_\_\_

- Unintentional weight loss or gain of 10 pounds or more in the last three months

Do you wear:

- Corrective lenses  Dentures  Hearing aid  Medical devices/prosthetics/implants, describe: \_\_\_\_\_

Recent change in your ability to:  see  hear  taste  smell  feel hot/cold sensations

- move around ( sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Do you:  Prefer warmth (i.e., food, drinks, weather, etc.)  Prefer cold (i.e., food, drinks, weather, etc.)  No preference

Is your sleep disturbed at the same time each night? \_\_\_\_\_ If yes, what time? \_\_\_\_\_

Do you experience any of these general symptoms EVERYDAY?

- |  |  |                                   |   |  |
|--|--|-----------------------------------|---|--|
| <input type="checkbox"/> Debilitating fatigue  | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Chronic pain/inflammation |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Panic attacks       | <input type="checkbox"/> Nausea   | <input type="checkbox"/> Fecal incontinence   | <input type="checkbox"/> Bleeding                  |
| <input type="checkbox"/> Disinterest in sex    | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Discharge                 |
| <input type="checkbox"/> Disinterest in eating | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Low grade fever      | <input type="checkbox"/> Itching/rash              |

**Medical History:**

- Arthritis
- Allergies/hayfever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose Vein

**Medical (Men):**

- BPH
- Prostrate Cancer
- Decreased sex drive
- Infertility
- Other \_\_\_\_\_
- \_\_\_\_\_

**Medical (Women):**

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- PMS
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- STD
- Other \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date of last gynecological exam \_\_\_\_\_
- Mammogram  +  -
- PAP  +  -
- Form of birth control \_\_\_\_\_
- # of children \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- C-section
- Surgical menopause
- Menopause
- Date of last menstrual cycle \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Interval of time between cycles \_\_\_\_\_ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots) \_\_\_\_\_

**Family Health History (parents and siblings)**

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Glaucoma
- Heart Disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other \_\_\_\_\_

**Health Habits:**

- Tobacco:
- Cigarettes: #/day \_\_\_\_\_
- Cigars: #/day \_\_\_\_\_
- Alcohol:
- Wine: #glasses/d or wk \_\_\_\_\_
- Liquor: #ounces/d or wk \_\_\_\_\_
- Beer: #glasses/d or wk \_\_\_\_\_
- Caffeine:
- Coffee: #6 oz cups/d \_\_\_\_\_
- Tea: #6 oz cups/d \_\_\_\_\_
- Soda w/caffeine: #cans/d \_\_\_\_\_
- Other sources \_\_\_\_\_
- Water: #glasses/d \_\_\_\_\_
- Exercise:**
- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- Less than 30 minutes
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Box
- Yoga

**Nutrition & Diet:**

- Mixed food diet (animal and vegetable resources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
- dairy  wheat  eggs
- soy  corn  all gluten
- Other \_\_\_\_\_

**Food Frequency:**

- Servings per day:
- Fruits (citrus, melons, etc.) \_\_\_\_\_
- Dark green or deep yellow/orange vegetables \_\_\_\_\_
- Grains (unprocessed) \_\_\_\_\_
- Beans, peas, legumes \_\_\_\_\_
- Dairy, eggs \_\_\_\_\_
- Meat, poultry, fish \_\_\_\_\_

**Eating Habits:**

- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

**Current Supplements:**

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals, describe \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveritrol, etc.)
- Herbs - teas
- Herb - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, photonutrient blends)
- Liquid meals (e.g., Ensure)
- Other \_\_\_\_\_

**Would you like to:**

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, Tylenol, Benodryl, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get fewer colds
- Get rid of allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)