ATHENS NATURAL MEDICINE

Naturopathic Medicine and Acupuncture

Health History (confidential)

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What are your most important health concerns?

_____
_____
_____
_____
_____
_____
_____
_____
_____

Who is your primary care physician or OB/GYN?

_____
_____

When did you last go to a doctor's office, or hospital? What was the reason?

_____
_____

Medications and Supplements:
List All Medications and Supplements that you currently take and the dosages?

_____
_____
_____
_____

Please check the box for any of the following that you currently take:

☐Pain relievers
☐Diet Pills
☐ Cortisone/prednisone
☐Thyroid medication
☐ Sleeping pills
☐ Antacids
☐ Laxatives
☐ Tranquilizers

Allergies
Do you have allergies to foods, drugs, or other environmental allergens? Please Explain:

_____
_____
_____

Immunizations
What immunizations have you had?

☐ Diphtheria
☐ Tetanus
☐ Pertussis
☐Measles, Mumps, Rubella
☐ Polio
☐ Chickenpox
☐ Shingles
☐ Pneumococcal
☐HIB
☐Cervical Cancer
Other_____

Childhood Illnesses Have you had any of the following illnesses?

☐ Scarlet fever ☐ Diphtheria
☐ Rheumatic fever ☐ Mumps
☐ Rubella ☐ Chicken pox
☐ Measles
☐ Pertussis/Whooping cough

Occupation_____

_____

Marital Status

□ Separated □Married

□Single □ Divorced □Partnered

How many children do you have?_____

With whom do you live?

□ Parents	□ Alone
□ Children	□Other
□Spouse	□ Friends

Habits

Do you exercise? How many days per week? How long & what type of exercise?

_____

_____

Do you eat three meals a day?

□Yes □No

Sleep well? □Yes □No

Do you average 6-8 hours of sleep?

□Yes □No

Awake rested? □Yes □No

Enjoy your work? □Yes □No

Spend time outside?□Yes □No

Take vacations? □Yes □No

Watch TV □Yes □No

How many hours per day?_____

Read? □Yes □No

How many hours per day?_____

Use recreational drugs?□Yes □No

Have you been treated for drug dependence? □Yes □No

Use tobacco? □Yes □No

Use alcohol? □Yes □No

Have you been treated for alcoholism?

□Yes □No

What are your main interests and hobbies?

_____

_____

_____

_____

Review of Symptoms

Check any of the following you have had in the past year. Place a **P** by those you have had in the past, but do not currently have

GENERAL

___Fatigue
Weight_____
Weight 1 year ago_____
Maximum weight_____
When_____
Height_____

SKIN

___Rashes
___Eczema, Hives
___Acne, Boils
___Staph infections
___MRSA positive
___Itching
___Fungal Infections
___Color Change
___Hair loss
___Dry skin/scalp
___Lumps
___Night sweats
___Slow healing ulcerations
___Flushing

NOSE AND SINUSES

___Frequent colds
___Nose bleeds
___Stuffiness
___Hay fever
___Sinus problems
___Deviated septum
___Loss of smell

EYES AND EARS

___Impaired vision
___Glasses/Contacts
___Eye pain
___Itchy eyes
___Tearing or dryness
___Double vision
___Glaucoma
___Cataracts
___Impaired hearing
___Ringing
___Earache/Infections
___Dizziness

MOUTH AND THROAT

___Frequent sore throat
___Sore tongue
___Gum problems
___Teeth grinding
___Gagging/Choking
___Hoarseness
___Dental cavities

HEAD & NECK

___Headache
___Migraine
___Faintness
___Dizziness
___Jaw Pain
___Swollen glands
___Goiter
___Pain or stiffness
___TMD

RESPIRATORY

___Cough
___Sputum
___Spitting up Blood
___Wheezing
___Asthma
___Bronchitis
___Emphysema
___Pneumonia
___Difficulty breathing
___Pain on breathing
___Shortness of breath
___Tuberculosis

CARDIOVASCULAR

___Heart disease
___Angina/chest pain
___High/low blood pressure
___Murmurs
___Blood clots
___Irregular heart beat
___Palpitations
___Swelling in ankles

CIRCULATION

___Easily bleed/bruise
___Anemia
___Deep leg pain
___Varicose veins
___Cold hands and feet

ENDOCRINE

___Hypothyroidism
___Hyperthyroidism
___Heat or cold intolerance
___Hypoglycemia
___Diabetes
___Excessive thirst
___Excessive hunger
___Fatigue

IMMUNE

___Chronic fatigue syndrome
___Chronic infections
___Chronically swollen glands
___Slow wound healing

MUSCULO-SKELETAL

___Joint pain or stiffness
___Arthritis
___Broken bones
___Muscle spasms or cramps
___Weakness
___Osteoporosis
___Restless leg syndrome
___Sciatica
___Chronic pain
___Low back pain
___Tendonitis/Bursitis

NEUROLOGIC

___Seizures
___Paralysis
___Muscle weakness

___Numbness or tingling
___Easily stressed
___Vertigo or dizziness
___Loss of balance
___Tics
___Other

GASTRO-INTESTINAL

___Heartburn/reflux
___Change in thirst
___Change in appetite
___Ulcer
___Nausea/vomiting
___Gas/bloating
___Belching
___Diarrhea
___Constipation
___Pain or cramps
___Mucus in stool
___Black/bloody stool
___Hemorrhoids
___Itching/burning anus
___Rectal pain
___Liver/gallbladder disease
___Jaundice
___IBS
___Diverticulitis
Bowel Movements
How often?
_____
Is this a change?
_____
_____

URINARY

___Pain on urination
___Increased frequency
___Frequency at night
___Inability to hold urine
___Frequent infections
___Kidney stones

MENTAL EMOTIONAL

___Depression
___Anxiety
___Mood Swings
___Tension/Stress
___Bipolar
___Seasonal depression

MALE ONLY

___Hernias
___Testicular masses
___Testicular pain
Are you sexually active?
☐Yes ☐No
___Sexual difficulties
___Prostate disease
___Prostate cancer
___Sexually transmitted infections
___Discharge or sores
Sexual preference
___Heterosexual
___Bisexual
___Homosexual

FEMALE ONLY

Age menses began_____
Average number of days_____
Length of cycle_____
___Bleeding between periods
Cycles are regular ☐Yes ☐No
___Pain during intercourse
___Painful menses
___Excessive flow
Birth control ☐Yes ☐No
What type _____
Number of pregnancies ___
Number of live births___
Number of still births___
Number of miscarriages___
Number of abortions___
___Difficulty conceiving
___Menopausal symptoms
Sexually active ☐Yes ☐No
___Sexual difficulties
___Sexually transmitted infections
Sexual preference
___Heterosexual
___Bisexual
___Homosexual
Do you do self breast exams?
☐Yes ☐No
___ Lumps
___Pain or tenderness
___Nipple discharge

I certify this information is accurate to the best of my knowledge.

Signature _____

Print name Date

_____

Responsible party signs if patient is a minor