MEDICAL HISTORY/LIFESTYLE ASSESSMENT

Date: ___________________________

Name: ____
Last First

Phone: Home: ___________________ Cell: __________________

Work: ___________________ Fax: __________________

Email: ____

Date of Birth: _________________ Age: ____________ Sex: ____________

Height: ______________________ Weight: ____________

Marital Status: _______________________ No. of Children: _________

Occupation: _________________________

Address:

Number/Street: ____________________________ City: ____________________

State: _____________________________ Zip: ____________________

Pets (please list):
____

Primary Care Physician:

Name: ____

Address: ____

Telephone: ____

May we contact this practitioner? Yes ____ No ____

Who referred you: ____

What is your main reason for seeking consult today?

Please list any current medical problems:

Surgical procedures (please list any and all major or minor surgical procedures and the dates the procedures were performed):

Allergies to food or medication? If yes, please list:

Please list the names, dosage, frequency, and duration of all medications you are currently taking:

Name (How long?)	Dosage	Frequency

Please describe any neutraceutical, herbal or other OTC supplements you are currently taking, including:

Type	Dosage	How Long?

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MEDICAL HISTORY (SELF)

Your Past Medical History (circle all that apply to you):	*Diagnosis (list if applicable and any other useful information):*
Headaches	
Cancer (where, which type)	
Diabetes	
Heart Disease	
Arthritis	
Liver Disease	Hepatitis, cirrhosis, other
High blood pressure	
Elevated cholesterol	
Mental Concerns	Depression, anxiety, panic attacks, maniac depression, schizophrenia, other

HIV/AIDS ______________________________

Endocrine gland abnormalities Thyroid, pituitary, other ______________________________

Loss of energy ______________________________

Decreased self image ______________________________

Back/spine concerns ______________________________

Sleep concerns ______________________________

Neurological condition (stroke, seizures, Parkinson's disease, memory concerns, Alzheimer's disease, other):

____
____
____

Autoimmune Disease (lupus, rheumatoid arthritis, other):

____
____
____

Lung Disease (asthma, emphysema, other):

____
____
____

Kidney Disease (stones, infection, other):

____
____
____

Stomach Disease (ulcers, other):

____
____
____

Bowel Disease (lactose intolerance, Crohn's disease, diverticulitis, malabsorption, other):

____
____
____

Bladder Disease (loss of control, infections, other):

____
____
____

Memory Problems (short term memory, long term memory, please describe):

____
____
____

Sexual Concerns (please describe):

____
____
____

Exposure to chemicals or other toxins:

____
____

Exposure to excessive stress:

Osteoporosis:

Balance concerns:

Decreasing vision:

Carpal tunnel:

Sensory concerns(numbness, tingling, loss of feeling):

Slow or poor wound healing:

Frequent infections:

Date of last chest x-ray:

Date of last digital rectal exam:

Date of last cardiac stress test:

___

___

___

Date of last colonoscopy/sigmoidscopy:

___

___

___

WOMEN'S HEALTH (women only)

Have you ever used oral contraceptives? _______

If yes, please describe: ____

When was you last period: ____

Since you first began to have periods, have you ever had what YOU consider to be abnormal cycles?
____

Any problems with oral contraceptives? _______
If yes, please explain:____

Do you have or did you ever have premenstrual syndrome?
____

How many pregnancies have you had? _______ How many children? _______

How many interrupted pregnancies? _______

Have you had a hysterectomy? _______ If yes, provide date of surgery: _______

Have you had ovaries removed? _______ If yes, provide date of surgery: _______

Have you had a tubal ligation?: _______ If yes, provide date of surgery: _______

Date of last PAP smear and results:
____

Date of last mammogram and results:
____

MEN'S HEALTH (men only)

Any difficulty in maintaining/attaining an erection (or insufficient to maintain penetration)?
____

Ejaculation cause pain? ________ Pain/coldness in genital area? ________

Discharge from penis? ________

Sexual drive underactive? ________ Sexual drive overactive? ________

Premature ejaculation? ____

Infertility? ________________________ Low sperm count? ________

Past or present rash on penis? ________ Swollen genitals? ________

Swelling in groin? ________

Any past or present genital sores? ________ Jock Itch? ________

Past or present sexually transmitted diseases? ____
If yes, please describe: ____

Do you use Viagra or Cialis? ________ If yes, how often? ________
Has it helped you?____

Do you use any other medications for sexual function? _________________________________
If yes, please list and describe results: ____

Date of last prostate exam: ____

Date of last PSA: ____

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FAMILY HISTORY

#RELATIVE	AGE OR YEAR OF DEATH (Current age and health conditions; if deceased, please list age at death and cause of death)
Mother	
Father	
Siblings	
Children	
Grandchildren	

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING?

DIAGNOSIS (list if applicable and any other useful information, including which family member(s) experienced the disease and/or symptoms)

Headaches ______________________________

Cancer (where, which type) ______________________________

Diabetes ______________________________

Heart Disease ______________________________

Arthritis ______________________________

Liver Disease ______________________________

Mental Concerns ______________________________

Neurological Disease ______________________________

Autoimmune Disease ______________________________

Lung Disease ______________________________

Kidney Disease ______________________________

Stomach Disease ______________________________

Bowel Disease ______________________________

Osteoporosis ______________________________

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NUTRITION

In the past few months your weight has (circle one):

a) been increasing
b) been decreasing
c) remained the same
d) has been fluctuating up and down

What is the heaviest you have ever weighed (excluding pregnancy)?

a) your present weight
b) around 10 lbs heavier than your present weight
c) between 10-25 lbs heavier than your present weight
d) more than 25 lbs heavier than your present weight

What is the lightest you have weighed since graduating high school?

a) your present weight
b) around 10 lbs lighter than your present weight
c) between 10-25 lbs lighter than your present weight
d) more than 25 lbs lighter than your present weight

What is a realistic goal weight for you to maintain in the future? ____________ lbs.

How many meals to you eat per day?
____

How much water do you drink a day?
____

Please list any food allergies:
____
____
____
____

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DRUG USAGE

Marijuana use (how often, how long?):
____

Alcohol use (how many drinks and frequency):
____

Tobacco use (what type, how often, how many years):
____

Cocaine use (mode, how often, how long):
____

Psychedelic drug use (LSD, ecstasy, other):
____

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TYPICAL DAILY FOOD INTAKE

List the food consumed you consume on a mindful (good eating) day and an unprepared (bad eating) day. Please be specific, including amount of foods, beverages & supplements.

Mindful Day Wake Up Time:_______________ Bed Time: ____________________

Meal	Time	Food/Beverage & Amount
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Unprepared Day Wake Up Time:_______________ Bed Time: ____________________

Meal	Time	Food/Beverage & Amount
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

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EXERCISE

Please describe your exercise history (types and intensity throughout your life):

____
____
____
____

What type of physical activity have you participated in within the last 6 months?

____
____
____
____

What are you short-term and long-term exercise goals?

____
____
____
____

What type of physical limitations do you have (injuries, mobility issues, etc)?

____
____
____
____

Describe your current exercise program (type, duration, frequency of cardio, resistance, flexibility):

____
____
____
____

How do you manage your stress? (meditation, prayer, yoga, tai chi, massage). Please include type, duration, and frequency:

____
____
____
____