Integrated Health Center
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NOTES:

Name ____________________
Address ____________________
____

Telephone# (   ) ____________________
Date of Birth: ____________ Referred by: ____________
Occupation: ____________________
Family Physician: ____________________

Primary Problem #l: ____________________
When did it start? ____________________
Describe how it started: ____________________
____
Where is the symptom/or pain located? ____________________
What makes it worse? ____________________
What makes it better? ____________________

Problem #2: ____________________
When did it start? ____________________
Describe how it started: ____________________
____
Where is the symptom/or pain located? ____________________
What makes it worse? ____________________
What makes it better? ____________________

Problem #3: ____________________
When did it start? ____________________
Describe how it started: ____________________
____
Where is the symptom/or pain located? ____________________
What makes it worse? ____________________
What makes it better? ____________________

Problem #4: ____________________
When did it start? ____________________
Describe how it started: ____________________
____
Where is the sympton/or pain located? ____________________
What makes it worse? ____________________
What makes it better? ____________________

For additional problems, please list and describe in above format on a separate page.

LIFE STYLE

1. **DIET:** What foods do you crave?

l) ____________ when? ____________
2) ____________ when? ____________
3) ____________ when? ____________
4) ____________ when? ____________

For additional foods, please list and describe in above format on a separate page.

What foods make you ill? ____________________
____

REVIEW OF SYSTEMS

Please check any symptoms which apply to you:

General:
now past
- ❏ ❏ current weight
- ❏ ❏ recent weight change
- ❏ ❏ weakness
- ❏ ❏ fatigue
- ❏ ❏ fever

Head:
- ❏ ❏ headache
- ❏ ❏ head injury
- ❏ ❏ hair loss or thinning
- ❏ ❏ dry, coarse hair

other ____________

Eyes:
- ❏ ❏ nearsightedness or farsightedness
- ❏ ❏ blurred or failing vision
- ❏ ❏ dry, burning or itching eyes
- ❏ ❏ eyes water excessively
- ❏ ❏ eyes sensitive to light
- ❏ ❏ night blindness
- ❏ ❏ bloodshot or puffy eyes

other ____________

Ears:
- ❏ ❏ earaches
- ❏ ❏ noises or ringing
- ❏ ❏ ear discharges
- ❏ ❏ loss of hearing
- ❏ ❏ lots of wax
- ❏ ❏ dizziness
- ❏ ❏ infection

other ____________

Nose and sinuses:
- ❏ ❏ frequent colds
- ❏ ❏ nasal stuffiness
- ❏ ❏ hay fever
- ❏ ❏ nosebleeds
- ❏ ❏ sinus trouble
- ❏ ❏ nability to smell or taste

other ____________

Mouth and throat:
- ❏ ❏ bleeding gums
- ❏ ❏ sore tongue
- ❏ ❏ frequent sore throats
- ❏ ❏ dry or chapped lips
- ❏ ❏ dry mouth
- ❏ ❏ clear throat a lot
- ❏ ❏ lots of cavities
- ❏ ❏ hoarseness
- ❏ ❏ cracks in comers of mouth

other ____________

Neck:
- ❏ ❏ lumps in neck
- ❏ ❏ "swollen glands"
- ❏ ❏ goiter
- ❏ ❏ pain in the neck

other ____________

Respiratory:
- ❏ ❏ cough
- ❏ ❏ spitting up mucous or blood
- ❏ ❏ difficulty breathing
- ❏ ❏ shortness of breath on exertion
- ❏ ❏ chest pain
- ❏ ❏ wheezing
- ❏ ❏ asthma

Respiratory: *(Cont)*
now past
- ❏ ❏ bronchitis
- ❏ ❏ emphysema
- ❏ ❏ pneumonia
- ❏ ❏ tuberculous
- ❏ ❏ pleurisy

other ____________

Cardiac:
- ❏ ❏ heart trouble
- ❏ ❏ rheumatic fever
- ❏ ❏ heart murmurs
- ❏ ❏ difficulty breathing
- ❏ ❏ edema
- ❏ ❏ chest pain
- ❏ ❏ palpitations
- ❏ ❏ tightness in chest
- ❏ ❏ discomfort at high altitudes
- ❏ ❏ dizzy or weak upon standing
- ❏ ❏ swollen feet, ankles or legs
- ❏ ❏ cold hands or feet
- ❏ ❏ hands or feet turn blue
- ❏ ❏ leg pains when walking
- ❏ ❏ varicose veins
- ❏ ❏ tendency to anemia
- ❏ ❏ high blood pressure
- ❏ ❏ low blood pressure

other ____________

Gastrointestinal:
- ❏ ❏ trouble swallowing
- ❏ ❏ heartburn
- ❏ ❏ loss of appetite
- ❏ ❏ nausea
- ❏ ❏ vomiting
- ❏ ❏ vomiting of blood
- ❏ ❏ indigestion
- ❏ ❏ constipation
- ❏ ❏ rectal bleeding
- ❏ ❏ black tarry stools
- ❏ ❏ diarrhea
- ❏ ❏ abdominal pain
- ❏ ❏ food intolerance
- ❏ ❏ excessive belching
- ❏ ❏ passing of gas
- ❏ ❏ hemorrhoids
- ❏ ❏ jaundice
- ❏ ❏ liver or gall bladder trouble
- ❏ ❏ hepatitis

other ____________

Urinary:
- ❏ ❏ difficulty urinating
- ❏ ❏ blood in urine
- ❏ ❏ urinate frequently at night
- ❏ ❏ incomplete urination or dribbling
- ❏ ❏ pain when urinating
- ❏ ❏ lower back pain
- ❏ ❏ urgency when urinating
- ❏ ❏ hesitancy when urinating
- ❏ ❏ incontinence urinary
- ❏ ❏ infections, stones

Female:
- ❏ ❏ lumps in breasts
- ❏ ❏ pain in breasts
- ❏ ❏ nipple discharge
- ❏ ❏ swollen breasts
- ❏ ❏ self-examination (how often?) ________
- ❏ ❏ irregular menstruation
- ❏ ❏ bleeding between periods or after intercourse
- ❏ ❏ pain prior to or with periods

Female: *(Cont)*
now past
- ❏ ❏ depressed, tense or irritable around periods
- ❏ ❏ diminished or excessive sexual desire
- ❏ ❏ difficulty having orgasm
- ❏ ❏ inability to conceive
- ❏ ❏ miscarriages or abortions
- ❏ ❏ vaginal discharge
- ❏ ❏ pain, discomfort or itching in genital area
- ❏ ❏ hot flashes
- ❏ ❏ menopause
- ❏ ❏ venereal disease
- ❏ ❏ symptoms occur in monthly pattern

________ age at first menses
________ frequency of menses
________ duration of menses
________ date of last Pap smear
________ was it normal?
________ type of birth control

other ____________

Male:
- ❏ ❏ prostrate problems
- ❏ ❏ difficult or unusual urination
- ❏ ❏ discomfort or pain in genital area
- ❏ ❏ diminished or excessive sexual desire
- ❏ ❏ difficulty maintaining an erection
- ❏ ❏ discharge from or sores on penis
- ❏ ❏ history of venereal disease
- ❏ ❏ hernias
- ❏ ❏ testicular pain or masses

other ____________

Musculoskeletal:
- ❏ ❏ joint pains or stiffness
- ❏ ❏ muscle pains or stiffness

where? ____________
- ❏ ❏ arthritis
- ❏ ❏ gout
- ❏ ❏ backache
- ❏ ❏ bone pains
- ❏ ❏ painful feet, ankles or calves
- ❏ ❏ tremors or twitches
- ❏ ❏ loss of strength
- ❏ ❏ hernia
- ❏ ❏ muscle wasting
- ❏ ❏ limitation of motion

where? ____________
other ____________

Skin:
- ❏ ❏ acne or pimples
- ❏ ❏ hives
- ❏ ❏ rashes
- ❏ ❏ lumps
- ❏ ❏ itching
- ❏ ❏ dryness
- ❏ ❏ color change
- ❏ ❏ changes in hair or nails
- ❏ ❏ skin ulcers or sores
- ❏ ❏ dryness, roughness or scaling skin
- ❏ ❏ bruise easily
- ❏ ❏ moles, warts or skin tags
- ❏ ❏ flush easily
- ❏ ❏ cuts heal slowly or scar badly
- ❏ ❏ feet burn
- ❏ ❏ nails weak, ridged or split

other ____________

Peripheral vascular:
now past
- ❏ ❏ tingling in legs or arms
- ❏ ❏ cramps
- ❏ ❏ thrombophlebitis

other ____________

Neurological:
- ❏ ❏ fainting
- ❏ ❏ blackouts
- ❏ ❏ seizures
- ❏ ❏ paralysis
- ❏ ❏ local weakness
- ❏ ❏ numbness
- ❏ ❏ tingling
- ❏ ❏ tremors
- ❏ ❏ memory loss

other ____________

Psychiatric:
- ❏ ❏ nervousness
- ❏ ❏ tension
- ❏ ❏ mood swings
- ❏ ❏ depression

other ____________

Endocrine:
- ❏ ❏ thyroid trouble
- ❏ ❏ heat or cold intolerance
- ❏ ❏ excessive sweating
- ❏ ❏ diabetes
- ❏ ❏ excessive thirst, hunger or urination

other ____________

Hematologic:
- ❏ ❏ anemia
- ❏ ❏ easy bruising or bleeding
- ❏ ❏ transfusions

possible reactions ____________

Habits:
Do you use any of the following?
- ❏ cigarettes or tobacco
  ____ packs per day
- ❏ coffee or black tea
  ____ cups per day
- ❏ alcohol
  ____ drinks per day/week/year
- ❏ marijuana or other drugs
  ____ times per week
- ❏ juices ____ glasses per day
- ❏ soda ____ glasses per day
- ❏ water ____ glasses per day
- ❏ milk ____ glasses per day

Supplements and Prescriptions:
(please list below:)

❏ Vitamins

____

____

❏ herbs or homeopathic remedies

____

____

❏ over the counter medications

____

____

❏ prescription medications

____

____

What is your worst time of day or night? ______________________________

What is your best time of day or night? ______________________________

NOTES:

PAST MEDICAL HISTORY

General state of health ______________________________

What | When | Where

List childhood illnesses ______________________________

List adult illnesses ______________________________

List surgeries ______________________________

List hospitalizations ______________________________

Have you been immunized? ______________________________

List allergies (foods, chemicals, medications, plants, pollens, insects, etc.)

FAMILY HISTORY - *List illness or cause of death*

Mother ______________________________

Father ______________________________

Brother(s) ______________________________

Sister(s) ______________________________

PATERNAL | MATERNAL

Grandmother ______________________________

Grandfather ______________________________

Uncles ______________________________

Aunts ______________________________

OTHER ______________________________

PSYCO-SOCIAL HISTORY

Born & raised: (where) ______________________________

Ancestry: ______________________________

Work history ______________________________

Work stress ______________________________

Married _____ Pregnancies _____ Living Children _____ Divorced_____

Committed relationship ______________________________

Any social or financial stress? ______________________________

Additional Comments ______________________________

2. EXERCISE:

NOTES:

State number of minutes you devote to exercise DAILY and the type of exercise you do

Type of Exercise	Minutes Per Day

3. RECREATION: What do you do for fun? (Circle)

read dance music meditate art craft

other (name) ____________________

4. SLEEP HABITS

Hours? _____ Refreshed or tired on waking? _____ Restless? _____ Perspiration? _____

How many covers do you use? _____ Do you throw off covers? _____

5. DREAMS

Describe any recurring dreams: ____________________

____

____

____

6. PERSPIRATION *Check one*

Do You perspire a lot? _____ If yes, when ____________________

Or, never perspire? ______ Any odor to your perspiration? _____

What part of the body perspires the most? ____________________

7. WEATHER PREFERRED *Check one*

❑ Spring ❑ Fall ❑ Summer ❑ Winter

How do you feel in: *Check one*

	not good	good	great
Hot humid weather	❑	❑	❑
Dry hot weather	❑	❑	❑
Thunderstorms	❑	❑	❑
Near the seashore	❑	❑	❑
Changing weather patterns	❑	❑	❑

8. IN GENERAL

Do you feel better in open air? ______ Do you like company? _____

How do you feel when you are consoled? ____________________

____

When upset with a situation/person/job, what do you do? *Check one*

❑ talk about it ❑ cry a lot ❑ clam up ❑ get into a rage

❑ other, Explain ____________________

What is your worst fear/nightmare? ____________________

____

____

How do you feel in a new situation, ie., parties/social events/public speaking? ____________________

____

____