Name_____ **Date** _____

Medical History: Check all boxes that are now or have been a part of your personal health history.(N) Never, (C) Current, (P) Past

N C P **GENERAL**
- ☐☐☐ Allergy
- ☐☐☐ Chills
- ☐☐☐ Convulsions
- ☐☐☐ Depression
- ☐☐☐ Dizziness
- ☐☐☐ Fainting
- ☐☐☐ Fatigue
- ☐☐☐ Headache
- ☐☐☐ Loss of Sleep
- ☐☐☐ Loss of Weight
- ☐☐☐ Nervousness
- ☐☐☐ Tremors
- ☐☐☐ Mood Swings

N C P **MUSCLE & JOINT**
- ☐☐☐ Arthritis
- ☐☐☐ Bursitis
- ☐☐☐ Hernia
- ☐☐☐ Low Back Pain
- ☐☐☐ Neck Pain or Stiffness
- ☐☐☐ Pain Between Shoulders

N C P **Pain or Numbness in:**
- ☐☐☐ Shoulders
- ☐☐☐ Arms
- ☐☐☐ Elbows
- ☐☐☐ Hands
- ☐☐☐ Hips
- ☐☐☐ Legs
- ☐☐☐ Knees
- ☐☐☐ Feet
- ☐☐☐ Sciatica
- ☐☐☐ Swollen Joints

N C P **GASTRO-INTESTINAL**
- ☐☐☐ Colon Trouble
- ☐☐☐ Constipation
- ☐☐☐ Diarrhea
- ☐☐☐ Difficult Digestion
- ☐☐☐ Gall Bladder Trouble
- ☐☐☐ Hemorrhoids
- ☐☐☐ Jaundice
- ☐☐☐ Liver Trouble
- ☐☐☐ Pain over Stomach
- ☐☐☐ Ulcers

N C P **E.E.N.T**
- ☐☐☐ Crossed Eyes
- ☐☐☐ Deafness
- ☐☐☐ Ear Ache
- ☐☐☐ Buzzing in Ears
- ☐☐☐ Enlarged Glands
- ☐☐☐ Eye Flashes
- ☐☐☐ Eye Pain
- ☐☐☐ Hay Fever
- ☐☐☐ Hoarseness
- ☐☐☐ Nasal Obstruction
- ☐☐☐ Sinus Infection
- ☐☐☐ Sore Throat
- ☐☐☐ Loss of Taste
- ☐☐☐ Loss of Balance
- ☐☐☐ Loss of Smell

N C P **CARDIOVASCULAR**
- ☐☐☐ Hardening Arteries
- ☐☐☐ High Blood Pressure
- ☐☐☐ Low Blood Pressure
- ☐☐☐ Pain Over Heart
- ☐☐☐ Cold Hands or Feet
- ☐☐☐ Slow Beating Heart
- ☐☐☐ Rapid Heart Beat
- ☐☐☐ Swelling Ankles

N C P **RESPIRATORY**
- ☐☐☐ Chest Pain
- ☐☐☐ Chronic Cough
- ☐☐☐ Difficulty Breathing
- ☐☐☐ Wheezing

N C P **GENITO-URINARY**
- ☐☐☐ Bed Wetting
- ☐☐☐ Blood in Urine
- ☐☐☐ Frequent Urination
- ☐☐☐ Can't Control Urination
- ☐☐☐ Painful Urination
- ☐☐☐ Prostate Trouble
- ☐☐☐ Sexually Transmitted Disease

N C P **FOR WOMEN ONLY**
- ☐☐☐ Cramps or Backache
- ☐☐☐ Excessive Menstrual Flow
- ☐☐☐ Hot Flashes
- ☐☐☐ Irregular Cycle
- ☐☐☐ Lumps in Breast
- ☐☐☐ Menopausal Symptoms
- ☐☐☐ Painful Menses
- ☐☐☐ Vaginal Discharge
- ☐☐☐ Miscarriage

Y N
- ☐☐ Are You Pregnant?

When was your last menstrual period?
_____

Family History: Has anyone in your family ever had any of the following conditions:
- ☐ Cancer _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure_____
- ☐ Allergies/Asthma_____
- ☐ Tuberculosis_____
- ☐ Arthritis_____
- ☐ Diabetes_____
- ☐ Lung Disease_____
- ☐ Nervouse System Disorder _____

Social History:

Do you now or have you in the past done any of the following:
- ☐ Smoked
- ☐ Drink Acoholic Beverages: How often? _____
- ☐ Controlled Substances

How is your diet? _____

Are you interested in learning more about our nutrition program? Yes No

Hospitalizations /Surgeries □ None
*Date*_____ - *Reason* _____
_____ - _____
_____ - _____
_____ - _____

Allergies
Medication/Supplement/Food Reaction
_____ _____
_____ _____

Gynecologic History *(for women only)*
Obstetric History *Check box if yes and provide relevant quantity*
□ Pregnancy_____ □ Vaginal Delivery_____ □ Caesarean Delivery_____ □ Miscarriage_____
□ Abortion_____
□ Living Children_____ □ Post-Partum Depression_____ □ Toxemia_____
□ Gestational Diabetes_____
□ Baby over 8 lbs. _____ □ Premature_____ □ Low Birth Weight (< 6lbs) _____
□ Breast Feeding Your Child *How long?* _____ □ Oral Contraceptives_____ *How long?* _____
Menstrual History
Age at first period: _____ Menses Frequency: _____ Length between menses: _____ Pain: □ Yes □ No
Clotting: □ Yes □ No Has your period ever skipped? □ Yes □ No How long? _____
Last Menstrual Period: _____
Do you use contraception? □ Yes □ No *If yes:* □ Condom □ Diaphragm □ IUD □ Partner Vasectomy
Women's Disorders/Hormonal Imbalances
□ Fibrocystic Breasts □ Breast Cancer ___ /___ □ Endometriosis □ Fibroids □ Infertility
□ Painful Periods □ Heavy Periods □ PMS
Last Mammogram ____ /____ Anything Abnormal? _____ □ Breast Biopsy ____ /_____
□ Thermogram ____ /____ /____ Last PAP Test ___ / ___ / ___ □ Normal □ Abnormal
Are you in menopause? □ Yes □ No Age of onset of menopause: _____
Check box if you are experiencing
□ Hot Flashes □ Mood Swings □ Concentration/Memory Problems □ Vaginal Dryness
□ Decreased Libido □ Heavy Bleeding □ Joint Pains □ Headaches □ Weight Gain
□ Loss of Control of Urine □ Palpitations □ Painful Intercourse
□ Use of hormone replacement therapy *How Long?* _____ *What hormones and dosage?*_____

Men's History *(for men only)*
Have you had a PSA done? □ Yes □ No Date of last test? ___ /___ /____ Highest PSA Level: □ 0-2 □ 2-4 □ 4-10 □ >10
Check all that apply:
Do you regularly have morning erections? □ Yes □ No □ Increased fat accumulation □ Headaches
□ Emotional reactions □ Prostate enlargement □ Prostate infection □ Change in libido □ Impotence
□ Difficulty obtaining an Erection □ Difficulty maintaining an erection □ Prostate Cancer
□ Nocturia *(urination at night)* How many times a night? _____ □ Urgency/Hesitancy/Change in Urinary Stream
□ Loss of Control of Urine □ Testicular injury □ Testosterone replacement □ More fatigue and/or muscle soreness

Are you interested in learning about our nutrition program to address any of the above conditions? Yes No