EBB & FLOW INTEGRATED HEALTH

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PATIENT HEALTH HISTORY

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns in order of importance below:

Condition **Past Treatment**

a. _____ _____

How does this condition affect you? _____

b. _____ _____

How does this condition affect you? _____

c. _____ _____

How does this condition affect you? _____

d. _____ _____

How does this condition affect you? _____

4. Please lease list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction): _____

_____

5. Please list any medications with dosage (prescribed and over-the-counter), vitamins, and supplements you are currently taking: _____

_____

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6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. Family History:

Check those applicable:

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. Height: _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. Blood Pressure: What is your most recent blood pressure reading? _____/_____

When was this reading taken? _____

11. Childhood Illness (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. Immunizations (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

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13. **Hospitalizations and Surgeries:**

Reason	When
_____	_____
_____	_____
_____	_____

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When
_____	_____
_____	_____
_____	_____

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past): Mood Swings Nervousness Mental Tension

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past): Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past): Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past): Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Persistent Cough Pleurisy Asthma Tuberculosis Shortness of Breath
Other Respiratory Problems: _____

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past): Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

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20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past): Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain Gas/Bloating Food Sensitivities Constipation Diarrhea IBS
21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past): Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night
22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past): Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles Menopausal Symptoms Difficulty Conceiving Painful Periods
23. **Menstrual/Birthing History:**
    1. Age of First Menses: _____
    2. # of Days of Menses: _____
    3. Length of Cycle: _____
    4. Birth Control Type: _____
    5. # of Pregnancies: _____
    6. # of Miscarriages: _____
    7. # of Abortions: _____
    8. # of Live Births: _____
24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past): Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge
25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past): Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain Low Back Pain Leg Pain Joint Pain (if so, where?): _____
26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past): Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy
27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past): Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

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28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

_____

29. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y N Why/Why not? _____

g. Nicotine/Alcohol/Caffeine Use: _____

h. Have you experienced any major traumas? Y N Explain: _____

_____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Television habits: _____ Reading habits: _____

k. Interests and hobbies: _____

How did you hear about me? _____

Would you like to receive my email newsletter? _____