Please print | This information will be contained in your confidential medical history | Please print

SEATTLE HEALING ARTS
HEALTH HISTORY

Name (first, middle, last)	Age:	Today's Date:

PAST HISTORY

Please give names and dates

Major Illnesses:

previous hospitalizations or surgeries:

WELL BEING

Goals for Health:

What practices or activities do you use to sustain your health and well being?

Who do you turn to for support? Who are in your community?

Who lives in your household?

What causes stress for you?

DIET: ___Fast Food ___All American ___Vegetarian ___Balanced ___Other _____

SMOKING: Packs per day _____ Number of years _____ Years stopped _____ Pipe Cigar Chew

ALCOHOL: Never Occasional Moderate Heavy Alcohol Problem? Y N How much each week?

EXERCISE: Never Occasional Moderate Often Favorite types?

CAFFEINE: Coffee: _____ cups per day Tea: _____ cups per day

Height: _____ Weight _____ Weight at age 20 _____ Weight change last year: gain _____ lbs. lost _____ lbs.

OCCUPATIONAL EXPOSURES: _____ Asbestos _____ Other (describe)

DRUGS:

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

Drug allergies/Type of reaction: **ALLERGIES:**

Food sensitivities:

FAMILY HISTORY:		CHILDRENS AGES/NAMES	
	Diabetes		
	Heart disease		
	High blood pressure		
	Thyroid		
	Cancer		
	Alcoholism		
	Other		

Please complete other side

SEATTLE HEALING ARTS

HEALTH HISTORY - PAGE 2

PLEASE STATE YOUR CHIEF CONCERNS, MAIN PROBLEM, OR REASON(S) FOR SEEING THE DOCTOR:

SYSTEM REVIEW: Check if you have any symptoms or problems to any important or significant degree.

	Tired all the time		Frequent chest colds		Indigestion		Sugar in urine
	Don't feel well		Bronchitis		Heartburn		Hypoglycemia
	Weakness		Pneumonia		Nervous stomach		Low blood sugar
	Weight problem		Shortness of breath		Ulcers		Thyroid trouble
	Fluid retention		Asthma/wheezing		Vomiting blood	DATE OF last urinary or bladder infection:	
	Lack of exercise		Hayfever		Black or bloody stools		
DATE OF LAST PHYSICAL EXAM:			Pleurisy		Rectal bleeding		Bladder problems
			Chest pain		Abdominal pain		Kidney infection
	Headache		Heart trouble		Nervous or spastic colon		Kidney trouble
	Migraine		Heart murmur		Colitis		Kidney stone
	Fainting		Heart palpitation/racing		Diarrhea		Difficulty with urine
	Dizziness		Chest tightness/pressure		Constipation		Protein or blood in urine
	Epilepsy/seizure		Angina		Change in bowel habits		Sexually transmitted disease
	Ear/hearing problem		Tire easily		Hemorrhoids		Skin rash
	Ringing in the ears		Enlarged heart		Gall bladder trouble		Skin trouble
	Stuffy nose		Rheumatic fever		Hepatitis		Allergy
	Nose bleeds		Leg pain on walking		Liver disease		Food avoidance
	Sinus trouble		Varicose veins		Hernia		Bleed or bruise easily
DATE OF LAST DENTAL EXAM:			Phlebitis		Food intolerance		Anemia
			Ankle/leg swelling		Nervous		Blood disease
	Persistent hoarseness	DATE OF LAST CHEST X-RAY:			Tense/irritable		Infertility problem
	Glasses				Bored		Sexual difficulty
	Vision/eye trouble	DATE OF LAST Electrocardiogram:			Depressed		
	Glaucoma				Trouble sleeping	**MEN ONLY:**	
	Cataract		Arthritis/joint pain		Relationship problems		Discharge from penis
DATE OF LAST EYE EXAM:			Gout		Job problems		Prostate trouble
			Neck pain		Personal problems		Stream weak or slow
	Frequent cough		Back pain or trouble		Nervous breakdown		Swelling or pain in testes
	Cough phlegm		Bursitis/tendentious		Psychiatrist seen	DATE OF VASECTOMY:	
	Cough blood		Swallowing trouble		High blood sugar		

WOMEN ONLY:

Age menstruation began: _____ Periods: ____Regular ____Irregular ___Painful ___Heavy Every_____days

Comments: Last menstrual period date(s):_____

Number of PREGNANCIES:____ Number of BIRTHS:____ Number of Miscarriages/Abortions:____

Dates of PREGNANCIES / outcome:

Type of birth control: _____ How Long?_____ IUD? ____Yes ____No Years inserted _____

Date of last mammogram _____ History of breast disease?

Symptoms of menopause?

(Additions to health history)

Please complete other side