



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: _____

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 nutraceutical, herbal or other OTC supplements you are currently taking, including:

Type

Dosage

How Long?

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(numbsness, 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/sigmoidoscopy:



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: _____

FAMILY HISTORY

#RELATIVE	AGE OR YEAR OF DEATH (include reason for 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

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:

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):

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		

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 your 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:
