

# HEALTH HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Sex \_\_\_\_\_ Number of Children \_\_\_\_\_

Email \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Reason for office visit: \_\_\_\_\_ Date began: \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Practitioner name and phone number \_\_\_\_\_

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): \_\_\_\_\_

Outcome \_\_\_\_\_

What types of therapy have you tried for this problem(s):

- diet modification    fasting    vitamins/minerals    herbs    homeopathy    chiropractic    acupuncture    conventional drugs  
 other \_\_\_\_\_

List current health problems for which you are being treated: \_\_\_\_\_

Current medications (prescription or over-the-counter): \_\_\_\_\_

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): \_\_\_\_\_

Do you consider yourself:  underweight    overweight    just right   Your weight today \_\_\_\_\_

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? \_\_\_\_\_

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)? \_\_\_\_\_

- Corrective lenses    Dentures    Hearing aid    Medical devices/prosthetics/implants, describe: \_\_\_\_\_

Recent changes in your ability to:  see    hear    taste    smell    feel hot/cold sensations

move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors:  sour    bitter    sweet    rich/fatty    spicy/pungent    salty

Strong dislike for any one of the following flavors:  sour    bitter    sweet    rich/fatty    spicy/pungent    salty

Do you:  Prefer warmth (i.e., food, drinks, weather, etc.)    Prefer cold (i.e., food, drinks, weather, etc.)    No preference

Is your sleep disturbed at the same time each night? \_\_\_\_\_ If yes, what time? \_\_\_\_\_

Time of day you feel the most energy or the least symptoms:

- 7 a.m. - 9 a.m.    9 a.m. - 11 a.m.    11 a.m. - 1 p.m.  
 1 p.m. - 3 p.m.    3 p.m. - 5 p.m.    5 p.m. - 7 p.m.  
 7 p.m. - 9 p.m.    9 p.m. - 11 p.m.    11 p.m. - 1 a.m.  
 1 a.m. - 3 a.m.    3 a.m. - 5 a.m.    5 a.m. - 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

- 7 a.m. - 9 a.m.    9 a.m. - 11 a.m.    11 a.m. - 1 p.m.  
 1 p.m. - 3 p.m.    3 p.m. - 5 p.m.    5 p.m. - 7 p.m.  
 7 p.m. - 9 p.m.    9 p.m. - 11 p.m.    11 p.m. - 1 a.m.  
 1 a.m. - 3 a.m.    3 a.m. - 5 a.m.    5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

- |  |  |                                   |   |  |
|--|--|-----------------------------------|---|--|
| <input type="checkbox"/> Debilitating fatigue  | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Chronic pain/inflammation |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Panic attacks       | <input type="checkbox"/> Nausea   | <input type="checkbox"/> Fecal incontinence   | <input type="checkbox"/> Bleeding                  |
| <input type="checkbox"/> Disinterest in sex    | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Discharge                 |
| <input type="checkbox"/> Disinterest in eating | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Low grade fever      | <input type="checkbox"/> Itching/rash              |

## Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other \_\_\_\_\_

## Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other \_\_\_\_\_

## Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date of last gynecological exam \_\_\_\_\_
- Mammogram  +  -
- PAP  +  -
- Form of birth control \_\_\_\_\_
- # of children \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- C-section \_\_\_\_\_
- Surgical menopause
- Menopause
- Date of last menstrual cycle \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Interval of time between cycles \_\_\_\_\_ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) \_\_\_\_\_

## Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other \_\_\_\_\_

## Health Habits

- Tobacco:  
Cigarettes: #/day \_\_\_\_\_  
Cigars: #/day \_\_\_\_\_
- Alcohol:  
Wine: #glasses/d or wk \_\_\_\_\_  
Liquor: #ounces/d or wk \_\_\_\_\_  
Beer: #glasses/d or wk \_\_\_\_\_
- Caffeine:  
Coffee: #6 oz cups/d \_\_\_\_\_  
Tea: #6 oz cups/d \_\_\_\_\_  
Soda w/caffeine: #cans/d \_\_\_\_\_
- Other sources \_\_\_\_\_
- Water: #glasses/d \_\_\_\_\_

## Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Box
- Yoga

## Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:  
 dairy  wheat  eggs  
 soy  corn  all gluten
- Other \_\_\_\_\_

## Food Frequency

- Servings per day:  
Fruits (citrus, melons, etc.) \_\_\_\_\_
- Dark green or deep yellow/orange vegetables \_\_\_\_\_
- Grains (unprocessed) \_\_\_\_\_
- Beans, peas, legumes \_\_\_\_\_
- Dairy, eggs \_\_\_\_\_
- Meat, poultry, fish \_\_\_\_\_

## Eating Habits

- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

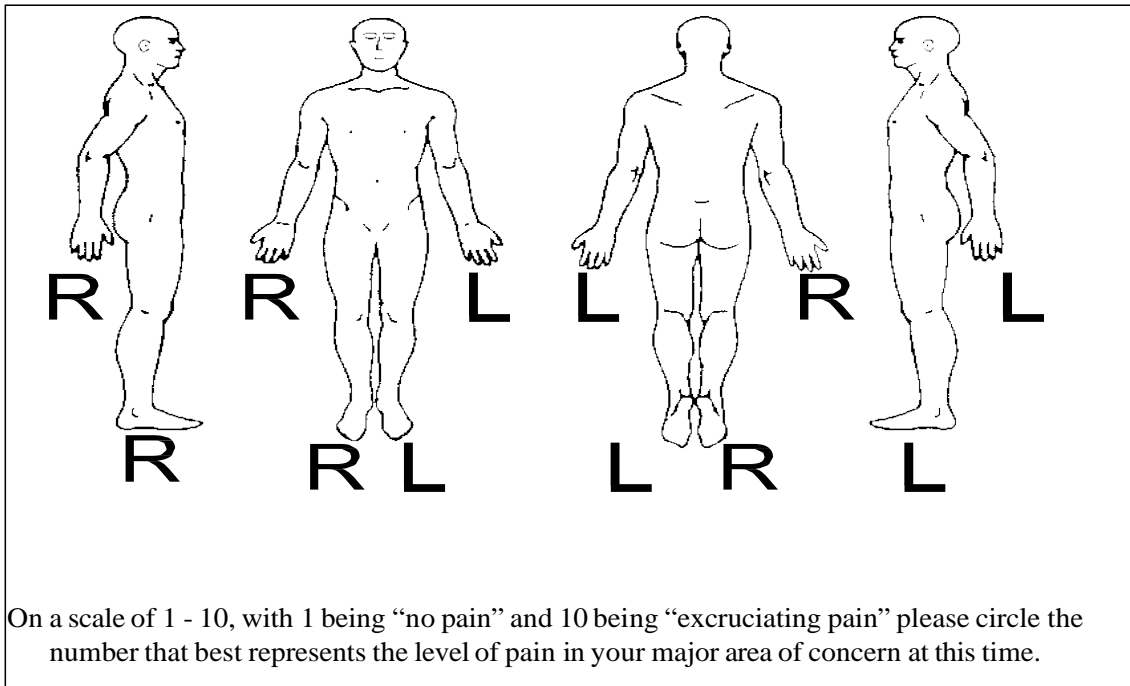
## Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals, describe \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other \_\_\_\_\_

## Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

If you are experiencing any pain, please show us where by marking it on the figures below:



1 2 3 4 5 6 7 8 9 10

No Pain . . . . .more pain. . . . .Excruciating Pain

Dr. Sera invites you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Please inform the doctor whenever you have a concern about your wellness care. By signing below you authorize treatment with the understanding of the information offered above and consent to allow necessary services and treatment according to the doctor's recommendations. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at time of service.

Name: \_\_\_\_\_

Date: \_\_\_\_\_