Restore HEALTH

3553 Clydesdale Pkwy. STE 230
Loveland, CO 80538
970-278-0900

PERSONAL HEALTH HISTORY FORM

DEMOGRAPHIC INFORMATION

Name (last, first, middle initial)		Social Security Number	Birthdate(mm/dd/yyyy)
Home Address – Line 1	City	State	Zip Code
Address Line 2	Home Phone	Work Phone	Cell Phone
Age Sex Male Female	Marital Status	Employer	Occupation
Email Address		How did you learn about us / Referred by:	
Emergency Contact Name/Relationship		Name of referring patient (if any)	
Name of spouse or significant other		Contact (phone 1)	Contact (phone 2)
Primary Care Physician		Physician Fax	Physician Phone
Preferred Pharmacy	Pharmacy City	Pharmacy Fax	Pharmacy Phone
Medicare Yes No	Race	Height (ex. 6'2")	Weight (lbs)
Insurance Carrier			

REASON FOR CONSULTATION

What health concerns and symptoms bring you to our office? Please be specific.
What would you most like to achieve with this health consultation?
Please list any questions or concerns that you have about our overall treatment program for you. The Doctor will make sure to address these during your visit and give you the information you need to make the best decision.

MEDICAL HISTORY

Please check any condition that you currently have or have had in the past.

Headaches (migraines, other)	Yes	No		Heart disease	Yes	No	
Seizures disorder	Yes	No		Chest pain	Yes	No	
Recurrent sinus Infections	Yes	No		Irregular heart beat	Yes	No	
Seasonal allergies	Yes	No		High blood pressure	Yes	No	
Psychiatric/emotional illness	Yes	No		Blood clotting problems	Yes	No	
Depression	Yes	No		Bleeding disorder	Yes	No	
Anxiety or excessive stress	Yes	No		Stroke/vascular disease	Yes	No	
Asthma	Yes	No		Constipation/diarrhea	Yes	No	
Chronic bronchitis	Yes	No		Hepatitis/liver disease	Yes	No	
Lung or breathing problems	Yes	No		Kidney disease	Yes	No	
Chronic indigestion	Yes	No		Menstrual disorders	Yes	No	
Stomach ulcers	Yes	No		Reproductive problems	Yes	No	
Intestinal disease	Yes	No		Prostate problems	Yes	No	
Skin problems/dermatitis	Yes	No		Sexual/ libido problems	Yes	No	
Back pain or sciatica	Yes	No		Tendonitis	Yes	No	
Herniated disc	Yes	No		Chronic pain problems	Yes	No	
Neck pain	Yes	No		Shoulder pain	Yes	No	
Chronic muscle or joint pain	Yes	No		Osteoarthritis	Yes	No	
Carpal tunnel syndrome	Yes	No		Rheumatoid arthritis	Yes	No	
Fibromyalgia	Yes	No		Artificial joint/implants	Yes	No	
Diabetes	Yes	No		Cancer	Yes	No	
Thyroid disease	Yes	No		Psoriasis or eczema	Yes	No	
Osteoporosis/osteopenia	Yes	No		Insomnia	Yes	No	

Provide explanations and list any additional health problems below:

List any surgeries/operations you have had and the year you had them:

Year	Surgery/Operation

MEDICAL HISTORY (continued)

Check the appropriate box below based on symptom severity

0=Never, 5=Most severe	0	1	2	3 4	5	
Fatigue						
Dry Skin						
Dry Hair						
Constipation						
Light Sensitivity						
Dizziness						
Low Blood Sugar						
Low Blood Pressure						
Cold Intolerance						
Heat Intolerance						
Cold Hands and Feet						
Thinning Eyebrows						
Hair Loss						
Irregular Hair Growth						
Skin Breakouts/Acne						
Environmental Allergies						
Food Sensitivities						
Sensitivity to smells						

BRAIN OR HEAD TRAUMA

How many episodes of brain trauma have you had in your life?

If 1 or more, please be specific and write down dates as well.

IMMUNE SYSTEM

Please list all infections over your <u>entire life</u> with the number of each. If none, enter 0

Strep Throat		Mono	
Pneumonia		Bronchitis	
Urinary Tract Infections		Prostatitis	
Sinusitis		Vaginal yeast infections/Jock Itch	
Gastroenteritis/Traveler's Diarrhea		Lyme's disease	
Colds and flus **PER YEAR**		Other infections	

Are you currently under the care of a health professional for any medical condition?
☐ Yes ☐No If yes, please provide name and explain condition and treatment
(Note: Do not put meds here)

List any medications you are currently taking or have taken in the recent past.

Medication Name	Year Started (yyyy)	Year Stopped (yyyy)	Dosage (amount/# daily)

List any vitamins, herbs or nutritional supplements that you are taking.

Vitamin/Mineral Name	Year Started (yyyy)	Year Stopped (yyyy)	Dosage (amount/# daily)

List any medication allergies that you are aware of:

List any environmental/food allergies that you are aware of:

Preventive Tests History

	Month/Year of last test	Test Results
Cholesterol		
Bone density		
Colonoscopy		
Exercise stress test		

MEDICAL HISTORY – FEMALE *(MEN, PLEASE SKIP TO NEXT PAGE).*

Are you currently pregnant?	☐Yes ☐No	First day of last cycle?	
How many pregnancies have you had?		How many children?	
How many Miscarriages?		How many abortions?	
Do you perform monthly self breast exams?	☐Yes ☐No		
Had a hysterectomy?	☐Yes ☐No	If yes, were your ovaries removed?	☐Yes ☐No
Has your abdominal girth and weight been increasing?	☐Yes ☐No		
Have you had any menstrual irregularities?	☐yes ☐No	*If yes, explain below:*	
Are you taking or have you taken hormones or oral contraceptives	☐Yes ☐No		

If yes, please list all hormones and oral contraceptives you have taken below:

Yr Started	Yr Stopped	List hormones or contraceptives here

Have you ever had any problems or concerns about taking hormone replacement therapy?

☐Yes ☐No *If yes, explain below:*

	Month/Year of last test	Test Results
Pap/pelvic exam		
Breast exam		
Mammogram		
Thermography		
Pelvic ultrasound		

Please check those conditions that you currently have or have had in the past

Condyloma	Yes	No	Memory lapse	Yes	No
Dizzy spells	Yes	No	Dribbling	Yes	No
Painful or difficult urination	Yes	No	Frequent nightime urination	Yes	No
Excessive urination	Yes	No	Pelvic pain	Yes	No
Hair loss	Yes	No	Painful intercourse	Yes	No
Blood in urine	Yes	No	Frequent urination	Yes	No
Irritability	Yes	No	Excessive itching	Yes	No
Snoring	Yes	No	Sexually transmitted disease	Yes	No
Stress incontinence	Yes	No	Sore breasts	Yes	No
Urge incontinence	Yes	No	Vaginal itching	Yes	No
Recurrent UTI's	Yes	No	Vaginal odor	Yes	No
Vaginal discharge	Yes	No	Weird dreams	Yes	No

MEDICAL HISTORY – FEMALE (continued)

Check the appropriate box below based on symptom severity with 5 being the most severe

0=Never, 5=Most severe	0	1	2	3 4	5	
Hot Flashes						
Night Sweats						
Vaginal Dryness						
Decreased Libido						
Insomnia						
Depression						
Anxiety						
Headaches						
Mood Swings						
Weight Gain						
Bloating						
PMS						
Acne						
Facial Hair Growth						
Brain Fog						

Menstrual History

Do you currently have menstrual cycles? ☐ Yes ☐ No

If no, when did they stop?

Are your menstrual Cycles: ☐ Regular ☐ Irregular? How frequently do you get them?

How many days of menstrual Flow do you have?

Is your flow: ☐ light ☐ medium ☐ heavy?

Do you have any of the following symptoms during your menstruation? (check all that apply)

☐ Cramps ☐ Cravings ☐ Insomnia ☐ Other None

Do you have the following symptoms Pre-Menstrually? (check all that apply)

☐ Bloating ☐ Water Retention ☐ Breast Tenderness ☐ Irritability ☐ Moodiness
☐ Insomnia ☐ Anxiety ☐ Depression ☐ Food Cravings None

Do you have a history of any of the following (check all that apply)

☐ Ovarian Cysts ☐ Uterine Fibroids ☐ Thyroid Nodule ☐ Fibrocystic Breasts

MEDICAL HISTORY – MEN ONLY

Date of last prostate exam	
Are you concerned with loss of muscle mass, tone or strength	☐Yes ☐No
Do you perform periodic testicular self examination	☐Yes ☐No
Has your abdominal girth and weight been increasing	☐Yes ☐No
Have you ever used any medication to treat ED If so please list the drug and how effective it was for you	☐Yes ☐No
Has the quality, frequency, intensity of your erections changed in the last ten years	☐Yes ☐No

Benign prostate hypertrophy	☐Yes ☐No	Erectile dysfunction	☐Yes ☐No
Circumcism	☐Yes ☐No	Prostate problems	☐Yes ☐No
Condyloma	☐Yes ☐No	Sexually transmitted disease	☐Yes ☐No

Explain yes answers below as needed:

MEDICAL HISTORY – MEN ONLY (continued)

Check the appropriate box below based on symptom severity with 5 being the most severe

0=Never, 5=Most severe	0	1	2	3	4	5	
Hot Flashes							
Night Sweats							
Loss of Muscle mass							
Decreased Libido							
Insomnia							
Depression							
Anxiety							
Headaches							
Mood Swings							
Irritability							
BPH Symptoms							
Loss of Enjoyment							
Diminished AM Erections							
Diminished Quality of Erections							
Poor Wound Healing							
Midline Weight Gain							
Decreased Mental Acuity							
Decreased Motivation							
Poor Recovery from Work-outs							
Decreased Exercise Tolerance							
Painful Urination							
Bed Wetting							
Frequent Urination							
Incontinence							
Hesitancy (urination)							
Dribbling							
Frequent nighttime urination							
Decreased urine flow							
Incomplete voiding							
Swelling of penis							
Testicular pain or swelling							
Urethral discharge							
Recurrent urinary tract infections							
Blood in urine							

Family History

Mother living?	Yes	No	*If no, provide age at death*	
Father living?	Yes	No	*If no, provide age at death*	
Family disease history			*Write relationship of the relative(s) with the disease on the adjacent lines*	
Heart disease	Yes	No		
High blood pressure	Yes	No		
Diabetes	Yes	No		
Arthritis	Yes	No		
Skin disorders	Yes	No		
Breast cancer	Yes	No		
Uterine/Ovarian Cancer	Yes	No		
Prostate cancer	Yes	No		
Colon cancer	Yes	No		
Other cancer	Yes	No		
Thyroid disease	Yes	No		
Autoimmune disease	Yes	No		
List any other diseases/conditions in the family and the relationship				

Social History

General

Overall health	☐ Excellent ☐ Good ☐ Fair ☐ Poor		
Physical fitness level	☐ Excellent ☐ Good ☐ Fair ☐ Poor		
Under a lot of stress	☐Yes ☐No	Fatigued all the time	☐Yes ☐No
Having difficulty dealing with stress	☐Yes ☐No	Often sad and blue	☐Yes ☐No
Practice meditation or other relaxation techniques	☐Yes ☐No		
Where were you born?			
Where did you grow up?			
Where did you go to highschool?			
Highest level of education?	☐ Some high school ☐ High school graduate ☐ Some college ☐ College graduate ☐ Post graduate studies ☐ Graduate degree		
Where did you go to college?			
What kind of work have you done?			
Do you currently work?	☐Yes ☐No		
What kind of work do you do now?			
How many hours do you work each day?			
How would you rate your level of stress at work?			
How would you rate your level of stress at home?			
What are your hobbies?			
What brings you the greatest joy in life?			

Dietary Habits

No special dietary habits	☐ True	Gluten free diet	☐ True	Minimizes fat	☐ True
Try to eat a healthy diet	☐ True	Min carbs	☐ True	Vegetarian	☐ True
Emphasize fruits, grains and vegetables	☐ True	Avoids dairy/cheese			☐ True
Commonly eat at fast food restaurants	☐ True	Commonly eat chocolate			☐ Yes
Commonly consume: Coffee	☐ Yes	Regular soda	☐ Yes	Diet soda	☐ Yes
Commonly consume: Candy	☐ Yes	Chocolate	☐ Yes	Chips	☐ Yes
What foods are you sensitive to or allergic to if any?					
What types of food do you crave?	☐ Sweets	☐ Salty	☐ Chocolate	☐ Spicy	☐ Sour
What percent of your diet is organic?	%	What percent do you cook at home?			%
What percentage of your diet is:					
1. Processed Foods	%	2. Sweet, Sugary Foods			%
3. Fats (Animal and Vegetable)	%	4. Protein			%

Exercise Habits

No special exercise habits	☐ True	Routinely exercise		hrs		x/week	
Aerobic exercise: Jog	☐ True	Walk	☐True	Treadmill	☐True	Swim	☐ True
Stretch/Yoga/Tai Chi	☐ True	Lift weights	☐True	Other			

Tobacco And Recreational Drug Use

I never smoked cigarettes or chewed tobacco	☐True	I smoke cigars/pipes	☐True		
I now smoke	packs of cigarettes per day. I have smoked for		years.		
I quit smoking in (mo/yr)	I smoked	packs/day for	Yrs.		
Have you ever used marijuana?	☐ Yes ☐ No	If yes, how long		how often	
Have you ever used cocaine?	☐ Yes ☐ No	If yes, how long		how often	
Have you ever used Psychodelic drugs (Ecstasy, LSD, other)?	☐ Yes ☐ No	If yes, how long		how often	
Other recreational drug use					
Any complusions or bad habits that you want to change?					

Alcohol Use

I never drink alcohol of any kind	☐True	I drink occasionally or socially	☐True	
I regularly drink: 1-2 drinks/day	☐True	Over 2 drinks/day	☐True	
Over 4 drinks/day	☐True	I typically drink (wine, beer, other)		

Hobbies/Sports/Recreation

List routine hobbies/sports/recreational activities:

Sexual History

Sexual orientation	☐ Heterosexual	☐ Homosexual	☐ Bisexual	☐ Other
How many sexual partners have you had?				
Do you have any history of trauma or abuse?	☐ Yes	☐ No	If yes:	
What would you like to improve about your sex life?				
Sexual desire is	☐ Optimal	☐ Less than desired	☐ More than desired	

Faith/Spirituality

Religion/Faith			
How do you practice your faith?			
How important is it to your life?	☐ Very	☐ Somewhat	☐ Little importance
How does your faith influence your daily life?			

Patient Signature _____ Date _____

Note:
To meet the needs of all of our patients, we require as much advance notice of cancellation as possible. If your cancellation is less than 48 hours prior to your appointment or you do not show, your credit card will be charged for the appointment and a rescheduling fee may apply. Our complete cancellation policy is provided on our web site at www.restorehealthcenter.net Click on fees and payment.