



# SanTan Natural Medicine

## HEALTH HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City, Zip \_\_\_\_\_ (H) Phone \_\_\_\_\_

Email \_\_\_\_\_ (W or C) Phone \_\_\_\_\_

Employer \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_\_\_ Number of Children \_\_\_\_\_

Marital Status  Single  Partner  Married  Separated  Divorced  Widow(er)

Are you recovering from a cold or flu? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Reason for office visit:

1 \_\_\_\_\_ Date condition began \_\_\_\_\_

2 \_\_\_\_\_ Date condition began \_\_\_\_\_

3 \_\_\_\_\_ Date condition began \_\_\_\_\_

List any health problems for which you are currently being treated:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What types of therapies have you tried for these problems or to improve your health overall:

diet  fasting  vitamin/minerals  herbs  homeopathy  chiropractic  acupuncture  conventional drugs  
 other \_\_\_\_\_

Do you experience any of these general symptoms EVERY DAY?

Panic attacks  Shortness of breath  Insomnia  Constipation  Chronic pain/Inflammation  Bleeding  
 Depression  Debilitating fatigue  Nausea  Fecal incontinence  Poor wound healing  Discharge  
 Dizziness  Disinterest in sex  Vomiting  Urinary incontinence  Low grade fever  Itching/rash  
 Headaches  Disinterest in eating  Diarrhea  Ringing in ears  Intolerant of cold

Laboratory procedures performed (blood, stool, urine, etc.) \_\_\_\_\_

Outcome \_\_\_\_\_

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 cause of stress (eg. work, finances, relationship(s), etc.) \_\_\_\_\_

What is your overall energy level on a scale of 1 to 10 (1 being the lowest, 10 the highest): 1 2 3 4 5 6 7 8 9 10

Do you consider yourself:  underweight  overweight  just right

Your weight today \_\_\_\_\_ lbs Your weight at age 20 \_\_\_\_\_ lbs Your ideal weight \_\_\_\_\_ lbs

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

Are you exposed to potentially harmful chemicals (eg. pesticides, solvents, etc.) \_\_\_\_\_

**Please continue on back ⇨**



## HEALTH HISTORY CONTINUED

Current medications (prescriptions or over-the-counter):

_____	_____	_____
_____	_____	_____
_____	_____	_____

List any known allergies:

_____	_____	_____
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List any known drug allergies:

_____	_____	_____
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How committed are you to making a change in your health (1 = least, 10 = most committed): 1 2 3 4 5 6 7 8 9 10

### Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Chest pain
- Cholesterol, elevated
- Circulatory problems
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy/seizures
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- IBD/colitis
- Irritable bowel syndrome
- Kidney or bladder disease
- Liver or gallbladder disease (stones)
- Mental illness
- Migraine headaches

- Neurological problems (Parkinson's, paralysis, etc)
- Stroke
- Thyroid problems
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other \_\_\_\_\_

### Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroid/ovarian cysts
- PMS (premenstrual syndrome)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Menopause
- Surgical menopause
- C-section. How many \_\_\_\_\_
- Date of last GYN exam \_\_\_\_\_
- PAP  +  -
- Mammogram  +  -
- Number of pregnancies \_\_\_\_\_
- Number of children \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date of last period \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Any recent changes in menstrual flow (eg. heavier, more clots, etc) \_\_\_\_\_

### Medical (Men)

- Benign prostatic hyperplasia
- Prostate cancer
- Decreased sex drive
- Infertility

### Family Health History (Parents and Siblings)

- Arthritis
- Asthma/lung disease
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Hypertension
- Infertility
- Mental illness
- Migraine headaches
- Obesity
- Osteoporosis
- Stroke
- Other \_\_\_\_\_

### Health Habits

- Smoke
- Use alcohol
- Caffeine (coffee, pop, etc.)
- Glasses of water/day \_\_\_\_\_
- Hours of sleep/night \_\_\_\_\_
- Number of stools/day \_\_\_\_\_
- Consistency of stools:
  - hard  soft  marbles
  - normal  other \_\_\_\_\_

### Exercise

- none
- 1 to 2 days per week
- 3 to 4 days per week
- 5 to 7 days per week
- Less than 45 minutes per workout
- More than 45 minutes per workout

### Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan

### Eating habits

- One meal per day
- Two meals per day
- Three meals per day
- Graze (small frequent meals)
- Eat constantly whether hungry or not
- Skip meals – which ones \_\_\_\_\_

### I Would Like To:

- |   |  |
|---|--|
| <input type="checkbox"/> Feel more vital      | <input type="checkbox"/> Have more endurance         |
| <input type="checkbox"/> Feel less pain       | <input type="checkbox"/> Sleep better                |
| <input type="checkbox"/> Lose weight          | <input type="checkbox"/> Be stronger                 |
| <input type="checkbox"/> Improve memory       | <input type="checkbox"/> Be less moody               |
| <input type="checkbox"/> Be less indecisive   | <input type="checkbox"/> Feel more motivated         |
| <input type="checkbox"/> Increase sex drive   | <input type="checkbox"/> Increase muscle tone        |
| <input type="checkbox"/> Use less medications | <input type="checkbox"/> Slow down accelerated aging |