FEMALE ADULT **Health History Summary** Date________________

Name_________________________________ Age_____ Birthdate___________ Blood type______

Address____________________________________ City______________ State____ Zip__________

Phone (home)_____________________ (work)____________________ (cell) ___________________

Email: ______________________________ Soc Sec # __________________________________

Occupation______________________________ (full/part time?) Employer______________________

Insurance Co.____________________________ Policy #_______________ Phone # _____________

Nearest Relative____ Phone___________________
what is their relationship to you?

Who else can we contact in case of emergency?_____________________________ Phone____________
what is their relationship to you?

How did you hear about the Tabor Hill Clinic? ____

Last physician or health practitioner seen/phone?___________________________ When? ______________

When was your last blood test?______________ What kind(s)? ________________________________

Your Current Health Problems
What is your **main** reason for coming in today? If you have a specific health condition please describe in detail. When was the very first time that you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation?

List in order of importance other health problems that are troubling you:

1)____ & length of time________________

2)____ & length of time_________________

3)____ & length of time_________________

4)____ & length of time_________________

Other problems:____

How long has your **main** problem been troubling you?____________________________________

Is your current "main problem" getting *[better, worse, same]* and for how long?______________

What kind of treatment have you received and from whom?_____________________________

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health practitioner for your current problem? ***(yes or no)*** or for any problem? ***(yes or no).***

What was the therapy and what were the results?____________________________________

____

Your Health History

The general state of your health is: **(excellent___) (good___) (avg___) (fair___) (poor___),**

and on the average describe your energy level from 1-10 (10 is highest & 1 lowest) "________"

When during the day is your energy the best?________________ worst?________________

What is your current approximate weight?_________ height?________ Weight one year ago_____

As an adult your max. Wt?______date______ (not include pregnancy) and lowest. wt._____date_______

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? ***(yes or no) Please circle***

1) ____date__________

2) ____date__________

3) ____date__________

4)____date__________

5)____date__________

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist?_______ Have you in the past?________ If so when?(give dates)_____________

Are you currently working with a Doctor of conventional medicine?(M.D. or D.O.)***(Yes or No)***

What childhood illnesses have you had? (check off if had)

measles ______	mumps_________	chickenpox________	whooping cough____
polio ______	diphtheria_______	rheumatic fever_____	scarlet fever________
smallpox______	typhoid fever_____	tuberculosis________	mono___ how long__

Previous surgeries and hospitalizations (include dates)_____________________________________

____

Which of the following have you had and indicate "now or past";.& also how often and when.

now or past	year	now or past	year	now or past	year
____pneumonia	_________	____diabetes	_______	_____gonorrhea	_______
____tonsillitis	_________	____asthma	_______	_____syphilis	_______
____ear infections	_________	____eczema	________	_____venereal disease	____
____chronic infections	______	____heart disease	____	______epilepsy	________
____canker sores	_______	____herpes	_________	_____high blood pressure	____
____allergies	______________	____hepatitis	_______	_____mononucleosis	____
____thyroid problems	_______	____weight prob.	____	_____anemia	_________
____auto immune disease	___	____cancer	__________	_____others	________________

Do you have any allergies to any drugs, herbs, foods, animals or other? ***(Y or N)*** What? _________

Which of the following do you currently use? Have you used in the past?

amount (how often, how much & how long) — amount (how often, how much & how long)

alcohol ______________________________ tobacco________________________________
birth control __________________________ marijuana______________________________
hormones _____________________________ coffee__________________________________
cortisone______________________________ laxatives________________________________
sedatives______________________________ antacids_________________________________

Have you ever had a drug or alcohol problem? Now or in past?________________________

other medications (please give full name and doseage and how long have you been taking the medication)

_________________________/ __________________________/ _______________________
_________________________/ __________________________/ _______________________
_________________________/ __________________________/ _______________________

vitamins\herbs________________/ ________________/__________________/___________
___________/ ________________/ __________________/ ________________/ ____________
___________/ ________________/ __________________/ ________________/ ___________

Family History

Please list ages, health problems and if deceased, cause of death:

	Living(age?)	Health Problems	Died (age?)	Cause
Your Mother	______	____________________________	____	__________________
Your Father	______	____________________________	____	__________________
Your Brothers	______	____________________________	____	__________________
	______	____________________________	____	__________________
	______	____________________________	____	__________________
Your Sisters	______	____________________________	____	__________________
	______	____________________________	____	__________________
	______	____________________________	____	__________________
Grandmom & granddad				
Mother's Mom	______	____________________________	____	__________________
Mother's Dad	______	____________________________	____	__________________
Grandmom & granddad				
Father's Mom	______	____________________________	____	__________________
Father's Dad	______	____________________________	____	__________________

What is your nationality? *(please list all backrounds & give approximate %)*_______________________

____

You currently live with? spouse___ partner___ parents___ friends___ children___ alone____

Are you? married____ separated___ divorced___ widowed___ single___ in a supportive relationship___

What is your current level of education?____________________ Are you satisfied with this? ***(Yes or No)***

Do you have any children?______ How many? ______ What are their ages?______________________

Do they have any health problems?____

Do you have any blood relative aunt uncle or grandparent who has had any of the following?

____allergies	____arthritis	____asthma	____cancer	____diabetes
____anemia	____depression	____skin disease	____heart attack	____genetic prob
____High B.P.	____stroke	____ulcers	____cataracts	____thyroid prob
____hypoglycemia	____seizures	____sickle cells	____venereal disease	

What is your weakest organ system and why?____

Personal Habits

What do you enjoy most in your life?____

What are your main interests or hobbies?____

What do you worry most about in life?____

What is the single most important thing to you in your life?___________________________

What are your life goals?____

Do you exercise? ***(yes/no)*** If yes what kind, how much & how often?____________________

Do you have a religious or spiritual practice? (***Yes/No***) If yes, what?______________________

On a scale of 1-10, how would you rate the quality of your sleep (10 being great) ___________

Do you have problems (*falling or staying asleep)*? ____ How many hrs do you sleep?________

Do you awaken at night? ***(yes or no)*** If yes what time(s) do you usually wake up?____________

Do you ever sweat at night while sleeping? ***(yes or no)***. How frequently and how much do you sweat?_____________________ Do you wake up feeling refreshed? ***(yes or no)***

Do you nap or rest horizontally throughout the day? ***(yes or no)***. For how long? ___________

Do you enjoy your work? ***(yes or no)*** Do you take vacations? **(*yes or no*)**

Are you currently in a happy satisfying relationship with someone? ***(Very, mostly, somewhat, not)***

How often do you get colds, flus, sore throat, yeast infections during the year?_____________

When you rise quickly from a sitting or lying position do you ever get dizzy? ***(yes or no***) *If yes how often?(**daily; few times per week; 1x week; 2x per month; 1x per month; rarely**)*

Female reproduction

Age of first menses______ If periods have stopped at what age did they stop?_____________

Are your cycles regular ***(Y N)*** Period begins every _______ days. How long periods?______

Are your periods ***(Heavy, medium, light)*** & what color is blood?(***light red, dark red, medium, clots***)

Do you have any spotting or bleeding between periods ***(Y / N)*** Any cramps with period ***(Y / N)***

Do you have any premenstrual symptoms ?***(water retention, breast tenderness, irritability, depression, headaches, mood swings, food cravings)*** other __________________________

Number of pregnancies_______ Number of abortions______ Number of live births?_______

Number of miscarriages_______ Any problems gettting pregnant?_______________________

Ever have Toxemia or pre-eclampsia during pregnancy? **(Y or N)**

Do you get yearly PAP smears*?(Y /N)* Any abnormal PAP's? *(Y / N)* Breast lumps?*(Y / N)*

At what level is your current libido (sex drive)? ***(10 is the highest and 0 is the lowest)________***

Are you currently sexually active?*(Y / N)* How often?________ Is this ***(more or less)*** than 1 yr ago?

Do you use birth control? ***(Y / N)*** What type of birth control do you currently use?________

Have you ever been physically or sexually abused? ***(Y/N)*** How old and how often?_________

If yes, do you feel like this is currently effecting either your physical or mental health today? ***(Y/N)***

Digestion and Elimination

Digestion *(circle or fill in the answer)*

Do you have any problems with gas, bloating or fullness after eating? (**Yor N**). How often do you have gas, fullness or bloating after eating? ***(often, sometimes, never)***. How severe?______ Do you have gas in ***(the upper part of the abdomen or lower part or both areas)***?

How long have you had this problem?_____________

How often do you have bowel movements?_____________________________

Do you ever have any (**blood, mucus, undigested food, black stools**)?

Any rectal itching? **(Y/N)** Do your stools tend to be ***(formed or loose)***? How often do you have loose stools or diarrhea?___________Do you ever have alternating constipation and diarrhea? **(Y N)**

How often do you have thin, long and narrow stools? ***(often sometimes never)***

How often do you have small & hard stools?***(often, sometimes, never)***

Do you ever have yellow or light colored stools? (***often, sometimes, never)***

How often do your stools have a strong disagreeable odor? ***(often, sometimes, never)***

Have you ever fasted? ***(yes or no; juice or water)*** For how long have you fasted?__________

How did you feel while you were fasting?____

Have you traveled outside the U.S. in last 5 years? *(Y/N) Have you gone camping in last 5 yrs?(Y/N)*

Have you ever had an eating disorder now or past such as anorexia or bulimia? (Y / N)

What do you normally feel like temperature wise, compared to others? ***(warm or cooler or avg)***

What are the temperatures of your hands and feet generally? (***warmer or cooler or average)***

Do you have difficulty perspiring? ***(Y N)***.. Do you perspire when you exercise? ***(lightly, moderately, heavily)***. Do you perspire other times than when exercising? ***(Y N)*** When?

Does your perspiration have a strong smell? ***(Yes or No)***

Kidneys and bladder

Have you had recurrent bladder infections?*(Yes or No)* How were they treated?___________

How many bladder infections have you had in the last 3 years?__________________________

Do you have any burning sensation during or after urination? ***(Past or Present or now)***

Is your urine ***(dark yellow, bright yellow, cloudy, pale or clear)****?*

Does your urine have a strong odor to it? ***(Yes or No)***

Do you have difficulty starting or stopping when urinating? ***(Yes or No)***

Occupational/household

How long have you lived at your present address?____________________________

Where have you lived previously? _____________

(Please describe location, if old or new place, i.e., new construction, damp or moldy)

____

Do you have specialized air filtration at home? ***(yes or no)*** *Do you live in city?* ***(Yes or No)***

Do you work in an office building? ***(yes or no)*** Do the windows open? ***(yes or no)***

Do you have specialized air filtration at your work place? ***(yes or no)***

Do you work in the presence of toxic fumes or chemicals? ***(yes or no)***

Do any of your hobbies involve toxic materials? ***(yes or no)***

Are you exposed to second hand smoke currently? ***(yes or no)***

What do you use for your drinking water? ***(bottled, filtered, or tap water)***

Dental

How often do you see a dentist?___________ Do you have a regular dentist that you like? ***(yes or no)***

How often do you get your teeth cleaned?______ How many silver fillings do you have in mouth?____

Have you ever had any root canals?_________________________ Do you still have your wisdom teeth in? (***yes or no***) Do you have any ongoing problems with your teeth including pain, discomfort or jaw pain?________________________

What are your immediate health goals?____

How long do you want to live?__________ How many years do you expect to live?____________

Was this health history summary (too long or too short or just right)

Do you have anything else you would like to comment on? __________________________________

____