SANDHILLS CHINESE HERBAL SCIENCE

HEALTH HISTORY FORM

Full name_____ Today's date _____

Mailing address _____

City _____ State _____ Zip _____

Street address, if different_____

City _____ State _____ Zip _____

Home phone (include area code) _____ Business/Work Phone _____

Age _____ Date of birth _____ Sex _____ Marital Status _____

Occupation _____ Religious affiliation, if any _____

I was referred by _____

Reason for referral_____

Nearest friend or relative _____

Mailing address _____

City _____ State _____ Zip _____

Give the following information about your immediate family's health:

Relationship	Age, if living	Age at death	State of health or cause of death
Father			
Mother			
Brothers & Sisters			
Spouse			
Children			

Have any of your blood relatives had any of the illnesses listed below? If so, indicate relationship (father, sister, etc.)

Illness	Family Member(s)	Illness	Family Member(s)
Asthma		Glaucoma	
Tuberculosis		Rheumatoid Arthritis	
High Blood Pressure		Gout	
Heart Disease		Rheumatic Fever	
Stroke		Epilepsy	
Diabetes		Mental Disorder	
Cancer		Alcoholism	
Blood Disease			

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List all surgery, hospitalization and serious Injuries you have had:

Year	Surgery, Illness or Injury	Hospital and City
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any of the following illnesses and disorders you have or have had and indicate the approximate year when each

	(X)	Year
eye or eyelid infection	_____	_____
glaucoma	_____	_____
other eye problems	_____	_____
	_____	_____
ringing in the ears	_____	_____
deafness or poor hearing	_____	_____
other ear problems	_____	_____
headaches	_____	_____
head injury	_____	_____
stroke	_____	_____
convulsions or seizures	_____	_____
allergies, asthma, hay fever	_____	_____
strep throat	_____	_____
bronchitis	_____	_____
pneumonia	_____	_____
tuberculosis	_____	_____
emphysema	_____	_____
other lung problems	_____	_____
high blood pressure	_____	_____
heart attack	_____	_____
heart murmur	_____	_____
high cholesterol	_____	_____
arteriosclerosis	_____	_____
other heart condition	_____	_____
thyroid disorder	_____	_____
diabetes	_____	_____

	(X)	Year
stomach or duodenal ulcer	_____	_____
colitis	_____	_____
diverticulosis	_____	_____
other bowel problem	_____	_____
hemorrhoids	_____	_____
hepatitis	_____	_____
other liver problems	_____	_____
gall bladder problems	_____	_____
hemia	_____	_____
kidney or bladder problems	_____	_____
prostate problems	_____	_____
arthritis	_____	_____
gout	_____	_____
cancer or tumor	_____	_____
bleeding tendency	_____	_____
measles/rubeola	_____	_____
German measles/rubella	_____	_____
scarlet fever		
chicken pox	_____	_____
mumps	_____	_____
polio	_____	_____
mononucleosis	_____	_____
eczema	_____	_____
psoriasis	_____	_____
venereal disease	_____	_____
Other……..	_____	_____

Please explain:_____

List the current challenges which are of the most concern to you.

Date Began	Challenge
_____	_____
_____	_____
_____	_____

List any disorders for which you are being treated by another health care practitioner.

Illness or disorder	Practitioner's name	City
_____	_____	_____
_____	_____	_____
_____	_____	_____

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List all medications you are now taking, Including non-prescription drugs and nutritional supplements.

List Items to which you are allergic (e.g., foods, medications, penicillin, bee stings, pollens, dust, chemicals, soaps, etc.), and Indicate how each Item affects you.

Fill In the years In which you had the following Inoculations:

Tetanus _____ measles _____ mumps _____

polio _____ typhoid _____ influenza _____

Other _____

Have you traveled in a foreign country in the last 20 years? No Yes

Country traveled in	Date(s)
_____	_____
_____	_____
_____	_____

Have you had a tuberculin (TB) skin test? No ____ Yes ____

If so, the date of test was _____ and the result was: ….. Negative Positive

	No	Yes
Have you ever worked or spent time……..on a farm ?	_____	_____
in a laundry or mill?	_____	_____
in a very dusty place?	_____	_____
in a mine?	_____	_____
with or near toxic chemicals?	_____	_____
with or near radioactive chemicals?	_____	_____
with or near asbestos?	_____	_____

Have you recently had any changes in your: (If yes; please explain on line to left.)

	No	Yes
_____marital status?	_____	_____
_____ job or work?	_____	_____
_____financial status?	_____	_____
_____residence?	_____	_____
_____ Are you having any legal problems?	_____	_____

What is your present weight? _____lb

What is your present height now? _____ft _____in

Presently, how is your general health?..... Good_____ Fair _____ Poor _____

How has your health been most of your life? …….. Good_____ Fair _____ Poor _____

In the past year:……has your appetite changed? Stayed the same_____ Increased _____ Decreased _____

has your weight changed? No change _____ Gained _____ lb Lost _____ lb

are you often noticeably thirsty? No _____ Yes _____

your general energy level changed? Stayed the same _____ Increased _____ Decreased _____

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HEALTH HISTORY FORM

	Rarely/Never	Sometimes	Often
Do you:……become tired easily?	_____	_____	_____
feel depressed?	_____	_____	_____
feel bored most of the time?	_____	_____	_____
have trouble making decisions?	_____	_____	_____
worry a lot?	_____	_____	_____
feel nervous?	_____	_____	_____
have trouble relaxing?	_____	_____	_____
become angry easily?	_____	_____	_____
have sexual problems?	_____	_____	_____
ever feel like committing suicide?	_____	_____	_____
use marijuana?	_____	_____	_____
use hard drugs?	_____	_____	_____

	No	Yes
……..……Do you often feel tired easily?	_____	_____
Have you ever fainted or felt like fainting?	_____	_____
Do you get cold hands or feet easily?	_____	_____
Do you sweat easily?	_____	_____
Do you often have difficulty sleeping?	_____	_____
, Do you often sleep restlessly?	_____	_____
Does any part of your body get numb?	_____	_____
Do you ever have fits or convulsions?	_____	_____
Do you ever shake or tremble?	_____	_____
Do you ever have any problem with coordination?	_____	_____
In the last 3 months have you had:…….a fever lasting more than a day?	_____	_____
any cold sores (fever blisters)?	_____	_____
sores or cuts that were hard to heal?	_____	_____
any lumps in your neck, armpit or groin?	_____	_____
chills or sweating at night?	_____	_____
Do you have:…….dry skin?	_____	_____
brittle fingernails?	_____	_____
any moles that have changed in color or in size?	_____	_____
any other skin problems?	_____	_____
Do you bruise easily?	_____	_____

	Rarely/Never	Sometimes	Often
In the past year have you had:……...feelings of nervousness?	_____	_____	_____
shoulder pain?	_____	_____	_____
back pain?	_____	_____	_____
muscle or joint stiffness or pain due to sports, exercise or injury?	_____	_____	_____
pain or swelling in any joints not due to sports, exercise or injury?	_____	_____	_____

…….Do you wear eyeglasses?	_____	_____
Do you wear contact lenses?	_____	_____
Has your vision changed in the last year?	Yes	No

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In the past year:	Rarely/Never	Sometimes	Often
How often do you have……double vision?	_____	_____	_____
blurry vision ?	_____	_____	_____
watery or itchy eyes?	_____	_____	_____
Do you:……...……..ever see colored rings around lights?	_____	_____	_____
have difficulty hearing?	_____	_____	_____
ever have ringing in your ears?	_____	_____	_____
ever feel dizzy or experience motion sickness?	_____	_____	_____
become angry easily?	_____	_____	_____
have trouble keeping your balance?	_____	_____	_____
have any discharge from your ears?	_____	_____	_____
How often do you have:……..……..headaches?	_____	_____	_____
neck pains?	_____	_____	_____

	No	Yes
Do you have problems with your:……...teeth?	_____	_____
gums, jaw, or roof of mouth?	_____	_____
tongue or taste sense?	_____	_____

	Rarely/Never	Sometimes	Often
How often do you have……...…….head colds?	_____	_____	_____
chest colds?	_____	_____	_____
runny nose?	_____	_____	_____
stuffed up nose?	_____	_____	_____
sneezing spells?	_____	_____	_____
nose bleeds?	_____	_____	_____
sore or hoarse throat?	_____	_____	_____
coughing spells?	_____	_____	_____
trouble breathing?	_____	_____	_____
coughing up of blood?	_____	_____	_____
earaches?	_____	_____	_____
…….Do you get short of breath when physically active?	_____	_____	_____
Do you sometimes feel light headed or dizzy?	_____	_____	_____
Have you ever fainted or passed out?	_____	_____	_____
Does your heart ever feel like it is racing or beating too fast?	_____	_____	_____
When you exercise do you get pains in your chest or shoulders?	_____	_____	_____
Do you have cramps or pain in your thighs or legs when walking?	_____	_____	_____
Do you need to sit up at night to breathe more easily?	_____	_____	_____
Do you use several pillows at night to help you breathe more easily?	_____	_____	_____
Do your legs cramp up at night?	_____	_____	_____
Do you have swollen ankles or feet?	_____	_____	_____
How often, if ever:……are you nauseated?	_____	_____	_____
do you belch a lot after eating?	_____	_____	_____
do you have heartburn?	_____	_____	_____
do you have stomach pains?	_____	_____	_____
is it difficult for you to swallow your food?	_____	_____	_____
have you vomited blood?	_____	_____	_____
are you constipated?	_____	_____	_____
do you have diarrhea?	_____	_____	_____
Are your bowels movements painful?	_____	_____	_____

Have you ever had a sigmoidoscopy?…….. No _____ Yes _____

	Rarely/Never	Sometimes	Often
……..Do you have difficulty beginning to urinate?	_____	_____	_____
Is urination painful?	_____	_____	_____
Do you have to urinate more than [5 times if you are male,8 times if female] per day?	_____	_____	_____
Do you get up at night to urinate?	_____	_____	_____
Do you ever urinate while sleeping?	_____	_____	_____
Do you ever lose urine when you laugh, cough, sneeze, or strain hard?	_____	_____	_____
Has your urine ever been bloody or dark colored?	_____	_____	_____
Has your urine ever been cloudy or milky in appearance?	_____	_____	_____

MEN ONLY:

	No	Yes
……..Do you have prostate trouble?	_____	_____
Do you have any sexual problems or impotency?	_____	_____
Have you ever had sores or lesions on your penis?	_____	_____
Have you ever had discharge from your penis?	_____	_____
Do you ever have pain, lumps or swelling in your testicles?	_____	_____

WOMAN ONLY:

What is the typical number of days between your menstrual periods?

the minimum is _____ days; the maximum is _____ days

	Rarely/Never	Sometimes	Often
Are they accompanied by:…….. ..pain and cramping?	_____	_____	_____
nausea?	_____	_____	_____
heavy bleeding or menstrual flow lasting longer than 4 days ?	_____	_____	_____
depression or irritability?	_____	_____	_____
Do you experience:……..……swelling and edema prior to menstruating?	_____	_____	_____
bleeding between periods?	_____	_____	_____
pain on intercourse or sexual activity?	_____	_____	_____
vaginal irritation or discharge?	_____	_____	_____
Do you ever have:……..……..……breast sensitivity?	_____	_____	_____

Do you receive regular breast exams from your physician?..... Yes _____ No _____

Date of : last gynecological exam _____ last pap smear _____

Name of gynecologist _____

	Start Date(s)	End Date(s)	Age(s)
List dates and ages when you have used birth control pills or an IUD:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

How much do you exercise? All I need _____ Less than I need _____ Little or none _____

What specific types of exercise or sports do you do, and how much per week?

_____

Do you smoke now?..... No _____ Yes_____
If yes, how many years? _____
How many each day? ____ cigarettes ____ cigars ____ pipe-fulls

Have you ever smoked? …….. No _____ Yes_____
If yes, how many years? _____
How many each day? ____ cigarettes ____ cigars ____ pipe-fulls

Do you drink alcoholic beverages? ……. No _____ Yes_____
Per day, I drink
_____ 12 oz cans of beer _____ 8 oz glasses of wine _____ oz of hard liquor (vodka, etc)

Have you ever had a problem with alcohol? ……... No _____ Yes_____

Do you drink coffee or tea (do not include herbal teas that do not contain significant levels of caffeine)? No _____ Yes_____
Per day, I drink _____ 8 oz cups

NUTRITION and DIET

How many meals do you eat each day? _____ meals

Do you usually eat breakfast? …… No _____ Yes_____

Do you diet frequently? …… No _____ Yes_____

Are you dieting now? …… No _____ Yes_____

Do you, in reference to your weight, consider yourself: ……. Just right ____ Overweight _____ Underweight ____

Do you snack? …….. Rarely _____ Dailey _____ More than once per day _____

Do you add salt to your food at the table? …… Rarely _____ Sometimes _____ Frequently _____

Check the frequency where which you eat the following foods:	more than once daily	daily	3 times weekly	once weekly	Rarely or never
whole grain cereal or bread	_____	_____	_____	_____	_____
other starches (pasta. white bread, etc.)	_____	_____	_____	_____	_____
sugar, desserts	_____	_____	_____	_____	_____
dairy products	_____	_____	_____	_____	_____
eggs	_____	_____	_____	_____	_____
fresh meat, poultry, fish	_____	_____	_____	_____	_____
smoked or processed meat	_____	_____	_____	_____	_____
beans, peas	_____	_____	_____	_____	_____
nuts and seeds	_____	_____	_____	_____	_____
citrus fruit or juice	_____	_____	_____	_____	_____
other fruit or juice	_____	_____	_____	_____	_____
dark green, deep yellow..... & orange vegetables	_____	_____	_____	_____	_____
other vegetables	_____	_____	_____	_____	_____
vinegar, pickled foods	_____	_____	_____	_____	_____

Additional challenges you wish to discuss:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Client's signature: _____

Clinician's comments:

_____
_____
_____
_____
_____
_____
_____
_____

After you complete this form please bring it to your first appointment or return it before your first appointment to:

SANDHILLS CHINESE HERBAL SCIENCE

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Mullen, NE 69152

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