

## East-West Wellness Patient Health History

Name: \_\_\_\_\_  
(first) (middle) (last)

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

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_\_

Gender: M / F

Marital status: S M D W

*Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.*

1. When and where did you last receive health care? \_\_\_\_\_

For what reason? \_\_\_\_\_

2. Has your case been referred to an attorney?      Y      N

3. Please identify the health concerns that have brought you to the Clinic in order of importance below:

**Condition**

**Past Treatment**

a. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

b. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

c. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

d. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

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

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

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

6. Do you have any reason to believe you may be pregnant?      Y      N

If so, how far along are you? \_\_\_\_\_

7. Do you have any infectious diseases?      Y      N      If yes, please identify: \_\_\_\_\_

<b>8. Family History:</b>	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** \_\_\_\_\_ **Weight:** Currently: \_\_\_\_\_ Past Maximum: \_\_\_\_\_ When? \_\_\_\_\_

10. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_\_ / \_\_\_\_\_ When was this reading taken? \_\_\_\_\_

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever      Diphtheria      Rheumatic Fever      Mumps      Measles      German Measles      Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio      Tetanus      Rubella/Mumps/Rubella      Pertussis      Diphtheria      Hib      Hepatitis B

Others: \_\_\_\_\_

13. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings                  Nervousness                  Anxiety                  Depression                  Mental Tension

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue                  Slow Wound Healing                  Chronic Infections                  Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision                  Eye Pain/Strain                  Glaucoma                  Glasses/Contacts                  Tearing/Dryness

Impaired Hearing                  Ear Ringing                  Earaches                  Headaches                  Sinus Problems

Nose Bleeds                  Frequent Sore Throats                  Teeth Grinding                  TMJ/Jaw Problems                  Hay Fever

18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia                  Frequent Common Colds                  Difficulty Breathing                  Emphysema

Persistent Cough                  Pleurisy                  Asthma                  Tuberculosis

Shortness of Breath                  Other Respiratory Problems: \_\_\_\_\_

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease                  Chest Pain                  Swelling of Ankles                  High Blood Pressure

Palpitations/Fluttering                  Stroke                  Heart Murmurs                  Rheumatic Fever                  Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers/GERD                  Changes in Appetite                  Nausea/Vomiting                  Epigastric Pain                  Gas/Bloating                  Heartburn

Belching                  Gall Bladder Disease                  Liver Disease                  Hepatitis B or C                  Hemorrhoids                  Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease                  Painful Urination                  Frequent UTI                  Frequent Urination                  Heavy Flow

Kidney Stones                  Impaired Urination                  Blood in Urine                  Frequent Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles                  Breast Lumps/Tenderness                  Nipple Discharge                  Heavy Flow

Vaginal Discharge                  Premenstrual Problems                  Clotting                  Bleeding Between Cycles

Menopausal Symptoms                  Difficulty Conceiving                  Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Menses: \_\_\_\_\_

4. Birth Control Type: \_\_\_\_\_

7. # of Abortions: \_\_\_\_\_

2. # of Days of Menses: \_\_\_\_\_

5. # of Pregnancies: \_\_\_\_\_

8. # of Live Births: \_\_\_\_\_

3. Length of Cycle: \_\_\_\_\_

6. # of Miscarriages: \_\_\_\_\_

24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties      Prostrate Problems      Testicular Pain/Swelling      Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain      Muscle Spasms/Cramps      Arm Pain      Upper Back Pain      Mid Back Pain  
Low Back Pain      Leg Pain      Joint Pain (if so, where?): \_\_\_\_\_

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness      Paralysis      Numbness/Tingling      Loss of Balance      Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid      Hypoglycemia      Hyperthyroid      Diabetes Mellitus      Night Sweats      Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia      Cancer      Rashes      Eczema/Hives      Cold Hands/Feet

Is there anything else we should know? \_\_\_\_\_  
\_\_\_\_\_

29. **Lifestyle:**

a. Do you typically eat at least three meals per day?      Y      N      If no, how many? \_\_\_\_\_

b. Exercise routine: \_\_\_\_\_

c. Spiritual practice: \_\_\_\_\_

d. How many hours per night do you sleep? \_\_\_\_\_      Do you wake rested?      Y      N

e. Level of education completed:      High School      Bachelors      Masters      Doctorate      Other

f. Occupation: \_\_\_\_\_      Employer: \_\_\_\_\_      Hours/Week: \_\_\_\_\_

Do you enjoy work?    Y/N    Why/Why not? \_\_\_\_\_

g. Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_

h. Have you experienced any major traumas?      Y      N      Explain: \_\_\_\_\_  
\_\_\_\_\_

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_

j. Television habits: \_\_\_\_\_      Reading habits: \_\_\_\_\_

k. Interests and hobbies: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Would you like to receive our email newsletter? \_\_\_\_\_