

## Harmony Healing Naturopathic Clinic

505 W. Olive Ave, #433, Sunnyvale, CA 94086 / (408) 730-0700

# ADULT HEALTH HISTORY FORM

**All questions contained in this questionnaire are strictly confidential  
and will become part of your medical record.**

<b>Name</b> <small>(Last, First, M.I.):</small>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB</b>	
<b>Marital status:</b>	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
<b>Previous or referring doctor:</b>		<b>Date of last physical exam:</b>	

**Please list your current health concerns in order of importance:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

<b>Childhood illness:</b>	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
<b>Immunizations and dates:</b>	<input type="checkbox"/> Tetanus		<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza		<input type="checkbox"/> MMR <small>Measles, Mumps, Rubella</small>

**List any medical problems that other doctors have diagnosed**


<b>Surgeries</b>		
Year	Reason	Hospital

<b>Other hospitalizations</b>		
Year	Reason	Hospital

<b>Have you ever had a blood transfusion?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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*Please turn to next page*

**List the prescribed medication / inhalers you are taking (including how much, how long, and how often)**

Name the Drug	Strength	Frequency Taken

**List the over-the-counter medications, including vitamins and herbs**

Name the Drug	Strength	Frequency Taken

**Allergies to medications or other**

Name the Drug / Substance	Reaction You Had

**HEALTH HABITS AND PERSONAL SAFETY**

On a scale of 1-10, how would you rate your energy (10 being the highest)?

On a scale of 1-10, how would you rate your quality of sleep?

During sleep do you:  Grind Teeth  Perspire  Talk  Snore  Walk  Have nightmares?

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

What do you do for work? Do you enjoy your work? (Yes / No)

Are you exposed to any hazardous substances? (Yes / No) If yes what?

Do you do any kind of physical activity? (Yes / No), if yes, what kind, how much & how often?

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

What is your current weight? \_\_\_\_\_ Height \_\_\_\_\_ Weight 1 year ago? \_\_\_\_\_  
 As an adult what has been your maximum \_\_\_\_\_ and minimum weight \_\_\_\_\_ (do not include pregnancy)

<b><i>Diet</i></b>	Are you dieting or on any dietary restriction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Which foods do you crave? <input type="checkbox"/> Sweet <input type="checkbox"/> Sour <input type="checkbox"/> Salty <input type="checkbox"/> Fats <input type="checkbox"/> Breads <input type="checkbox"/> Spicy <input type="checkbox"/> Bitter		

	Are you satisfied with your diet? If no briefly explain.			
	Water intake: (circle number of cups per day): 1 2 3 4 5 6 7 8 9 10			
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
<b>Alcohol</b>	Do you drink alcohol? If yes, what kind?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many drinks per week?			
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
<b>Drugs</b>	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sex</b>	Are you sexually active?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:			
	Any discomfort with intercourse?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Other</b>	Fears: <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Heights <input type="checkbox"/> Thunder/Lightning <input type="checkbox"/> Dark <input type="checkbox"/> Flying <input type="checkbox"/> Water			
	<input type="checkbox"/> Animals: Which ones? _____ <input type="checkbox"/> Other: _____			
	Sense of body temperature? <input type="checkbox"/> Chilly <input type="checkbox"/> Warm			
	Favorite Book or Movie?			

FAMILY HEALTH HISTORY				
	AGE	SIGNIFICANT HEALTH PROBLEMS	AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M
<b>Mother</b>				<input type="checkbox"/> F
<b>Sibling</b>	<input type="checkbox"/> M			<input type="checkbox"/> M
	<input type="checkbox"/> F		<input type="checkbox"/> F	
	<input type="checkbox"/> M		<input type="checkbox"/> M	
	<input type="checkbox"/> F		<input type="checkbox"/> F	
	<input type="checkbox"/> M		<b>Grandmother</b>	
	<input type="checkbox"/> F		<i>Maternal</i>	
	<input type="checkbox"/> M		<b>Grandfather</b>	
	<input type="checkbox"/> F		<i>Maternal</i>	
<input type="checkbox"/> M		<b>Grandmother</b>		
<input type="checkbox"/> F		<i>Paternal</i>		
<input type="checkbox"/> M		<b>Grandfather</b>		
<input type="checkbox"/> F		<i>Paternal</i>		

Do you have any blood relative who has had any of the following (check any that apply):

- |   |  |  |                                       |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Autism           | <input type="checkbox"/> Anemia        | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Syphilis     |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Depression    | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures     |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Brain Tumors        | <input type="checkbox"/> Sickle cells |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Schizophrenia       | <input type="checkbox"/> OCD          |
| <input type="checkbox"/> Tics             | <input type="checkbox"/> Gonorrhea     | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Aneurysms    |

**WOMAN ONLY**

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam: _____ Date of last mammogram: _____		
Ever have abnormal mammogram?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>MEN ONLY</b>		
Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?		

**Check conditions YOU have or ever had in the past:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Alcoholism                   | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Pneumonia          |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Psychiatric Care   |
| <input type="checkbox"/> Anorexia                     | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Bleeding disorders           | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Breast lump                  | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Bronchitis                   | <input type="checkbox"/> HIV Positive       | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Bulimia                      | <input type="checkbox"/> IBS                | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Sexually Transmitted disease | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Chemical Dependency          | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Colitis                      | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Emphysema                    | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Whooping Cough     |
|   | <input type="checkbox"/> Panic Attacks      | <input type="checkbox"/> Migraine Headaches |

## REVIEW OF SYSTEMS

**CIRCLE symptoms you currently have or had in the LAST 12 MONTHS**

<b>General:</b> Chills, Fever, weight loss, fatigue, cravings, weight gain, changes in appetite, trouble sleeping, cold hands/feet, night sweats, Poor memory, other:	<b>Cardiovascular:</b> Chest pain, high blood pressure, irregular heart beat, low blood pressure, poor circulation, swelling of ankles, varicose veins, difficulty breathing, other:
<b>Skin:</b> Bruise easily, eczema, psoriasis, hives, rash, itching, changes in moles, ulcerations, change in hair/skin texture, other:	<b>Musculoskeletal:</b> muscle weakness, muscle pain, back/neck pain, joint pain or swelling, injuries, numbness, other:
<b>Eye, Ear, Nose, Throat:</b> Bleeding gums, blurred vision, double vision, earache, ear discharge, hay-fever, hoarseness, loss of hearing, nosebleeds, ringing in ears, sinus problems, difficulty swallowing, cold sores, other:	<b>Gastrointestinal:</b> Poor appetite, bloating, constipation, diarrhea, bowel changes, vomiting, gas, hemorrhoids, indigestion, nausea, rectal bleeding, stomach pain, bad breath, belching, black stools, vomiting, vomiting blood, other:
<b>Neurological:</b> headache, dizziness, tremors, fainting, seizures, forgetfulness, nervousness or anxiety, numbness, other:	<b>Endocrine:</b> excessive thirst, excessive hunger, hormonal imbalances, heat/cold intolerance, other:
<b>Genito-urinary:</b> frequent urination, pain on urination, poor bladder control, kidney stones, wake up to urinate, blood in urine, other:	<b>Respiratory:</b> Persistent cough, shortness of breath, wheezing, coughing up blood, production of phlegm, difficulty breathing when lying down, tight chest, asthma, bronchitis, other:

### LIFESTYLE HABITS:

What behaviors or habits do you engage in regularly that support your health?

What behaviors or habits do you engage in regularly that poorly affect your health?

What are some obstacles that are challenging the kind of lifestyle you would like to live?

What are your expectations for today's visit?

Any additional information you would like to add:

*Thank you for your time and effort. We look forward to your visit.*