

Homeopathic Health Clinic

Minneapolis/St. Paul, Minnesota
www.homeopathichealthclinic.com

HEALTH INVENTORY

[THIS INFORMATION IS CONFIDENTIAL AND WILL ONLY BE RELEASED WITH YOUR SIGNED CONSENT]

Name _____ Today's Date _____
LAST FIRST INITIAL

Address _____ Birth date _____
CITY STATE ZIP COUNTY

Age ___ Sex ___ Height ___' ___" Weight ___
 Legal Status Single Married
 Divorced Separated Widow/er

Phone: WORK: _____ HOME: _____
 Emergency Contact Name: _____
 Phone # _____ Relation: _____
 If under 18, parents' name/address _____
 Elem ___ HS ___ Coll ___ Voc ___ Prof ___

Referred by: _____ Address: _____
 Family Physician: _____ Address: _____
 Retired: Yes No Semi
 Occupation _____
 e-mail Address _____

FAMILY HISTORY

Check if family history is unknown

	Age	If deceased, cause of death
Father		
Mother		
Siblings		

Children	Age	Problems

Check items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles).

YES	RELATIONSHIP
<input type="checkbox"/> Alcohol/drug problem	_____
<input type="checkbox"/> Allergy/asthma	_____
<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Arteriosclerosis	_____
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Binge eating/bulimia	_____
<input type="checkbox"/> Bleeding problem	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Epilepsy/seizure	_____
<input type="checkbox"/> Heart disease	_____
<input type="checkbox"/> Skin disease	_____
<input type="checkbox"/> Endocrine/hormonal imbalance	_____

YES	RELATIONSHIP
<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> High cholesterol/fat	_____
<input type="checkbox"/> Kidney disease	_____
<input type="checkbox"/> Liver disease	_____
<input type="checkbox"/> Mental illness	_____
<input type="checkbox"/> Obesity	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Suicide	_____
<input type="checkbox"/> Thyroid disease	_____
<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Gastro intestinal disease	_____
<input type="checkbox"/> Syphilis	_____
<input type="checkbox"/> Gonorrhea	_____

PAST HISTORY OF ILLNESS AND MEDICAL PROBLEMS

Surgery: List all surgery and approximate dates

Other hospitalizations and dates

Broken bones and/or traumatic injuries
(include all car accidents or concussions)

Current health problems
Example: High blood pressure – 10 yrs.

PAST HISTORY

YES	WHEN	YES	WHEN	YES	WHEN
<input type="checkbox"/> Acne	_____	<input type="checkbox"/> Epstein Barr/ infectious mono	_____	<input type="checkbox"/> Periodontal disease	_____
<input type="checkbox"/> AIDS	_____	<input type="checkbox"/> Fibrocystic breasts	_____	<input type="checkbox"/> Phlebitis	_____
<input type="checkbox"/> Alcohol/drug problem	_____	<input type="checkbox"/> Fibroids	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Gallbladder problem	_____	<input type="checkbox"/> Premenstrual tension	_____
<input type="checkbox"/> Amalgams/silver fillings	_____	<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Prostate problem	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Gonorrhea	_____	<input type="checkbox"/> Psychotherapy	_____
<input type="checkbox"/> Antibiotics more than once a year	_____	<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Reactions to	_____
<input type="checkbox"/> Anorexia	_____	<input type="checkbox"/> Hay fever	_____	<input type="checkbox"/> Vaccinations	_____
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> Hearing problem	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Arteriosclerosis	_____	<input type="checkbox"/> Heart attack	_____	<input type="checkbox"/> Root canal	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Heart failure	_____	<input type="checkbox"/> Scarlet fever	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Heart problem	_____	<input type="checkbox"/> Sexually transmitted disease	_____
<input type="checkbox"/> Back pain/strain	_____	<input type="checkbox"/> Hemorrhoids	_____	<input type="checkbox"/> Sinusitis	_____
<input type="checkbox"/> Binge eating	_____	<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Skin problem	_____
<input type="checkbox"/> Bladder infection	_____	<input type="checkbox"/> Herpes	_____	<input type="checkbox"/> Sleep disorder	_____
<input type="checkbox"/> Blood clots	_____	<input type="checkbox"/> Hiatal Hernia	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Breast lump	_____	<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Suicide attempt	_____
<input type="checkbox"/> Bronchitis	_____	<input type="checkbox"/> High cholesterol/triglycerides	_____	<input type="checkbox"/> Syphilis	_____
<input type="checkbox"/> Bulimia (self-induced vomiting)	_____	<input type="checkbox"/> Hives	_____	<input type="checkbox"/> Taken steroid (cortisone/prednisone)	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Hypoglycemia	_____	<input type="checkbox"/> Thyroid problem	_____
<input type="checkbox"/> Cataract	_____	<input type="checkbox"/> Insomnia	_____	<input type="checkbox"/> Tonsillitis	_____
<input type="checkbox"/> Chemical sensitivity	_____	<input type="checkbox"/> Kidney infection	_____	<input type="checkbox"/> Tooth problems	_____
<input type="checkbox"/> Chicken pox	_____	<input type="checkbox"/> Kidney stones	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Chronic fatigue	_____	<input type="checkbox"/> Kidney problem	_____	<input type="checkbox"/> Urine problem	_____
<input type="checkbox"/> Colds, frequent	_____	<input type="checkbox"/> Liver disease	_____	<input type="checkbox"/> Vaginitis	_____
<input type="checkbox"/> Colitis	_____	<input type="checkbox"/> Menstrual problem	_____	<input type="checkbox"/> Vision problem	_____
<input type="checkbox"/> Congenital defect	_____	<input type="checkbox"/> Mental illness	_____	<input type="checkbox"/> Warts	_____
<input type="checkbox"/> Counseling	_____	<input type="checkbox"/> Migraine	_____	<input type="checkbox"/> Other problems	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Nervous condition	_____	_____	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Neurological problem	_____	_____	_____
<input type="checkbox"/> Ear infection	_____	<input type="checkbox"/> Overweight (20 lbs)	_____	_____	_____
<input type="checkbox"/> Eczema	_____	<input type="checkbox"/> Panic Attacks	_____	_____	_____
<input type="checkbox"/> Endometriosis	_____	<input type="checkbox"/> Pelvic infection	_____	_____	_____
<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Peptic ulcer	_____	_____	_____

REVIEW OF SYSTEMS

Answer "yes" if you have had these symptoms *in the last 6 months.*

YES

- Chronic fatigue
- Mood swings
- Chronic depression
- Trembling episodes
- Light-headedness
- Food craving
- Frequent infection
- Night sweats
- Swollen glands
- Skin rash
- Chills/fever
- Change in skin/nails
- Change in wart or mole
- Abnormal bleeding/bruising
- Change in hair loss/growth
- Irritability
- Restlessness
- Headaches
- Dizziness
- Balance problem
- Head injury
- Seizure/convulsion
- Poor memory
- Difficulty concentrating
- Fainting
- Weakness
- Numbness/tingling
- Blurred vision
- Double vision
- Loss of any vision
- Halos around lights
- Excessive tearing/itching
- Eye pain
- Dark circles under eyes
- Date last eye exam _____
- Loss of hearing
- Ringing/buzzing in ears
- Sinus trouble
- Nosebleed
- Sore throat
- Hoarseness
- Change in voice
- Dental problem
- Dry mouth
- Excessive salivation
- Bleeding gums
- Mouth breather

YES

- Chronic cough
- Bloody/yellow sputum
- Shortness of breath
 - with exertion
 - at night
- Bronchitis
- Chest pain with breathing
- High blood pressure
- Chest pain or pressure
 - at rest
 - with exertion
 - with stress
 - with eating
 - down left arm, neck or back
 - accompanied by nausea, sweating, anxiety
- Irregular heartbeat
- Skip beats
- Palpitations
- Fast heart beat
- Heart murmur
- Swelling feet/legs
- Cold hands/feet
- Leg cramps at night
- Joint pain
- Pain or fatigue in legs with exercise
- Burning feet
- Sore legs/feet
- Color change legs/arms
- Difficulty swallowing
- Pain/discomfort when eating
- Bad teeth
- Belching
- Coating on tongue
- Canker sores
- Pain relieved by eating
- Nausea/vomiting
- Trouble with fried foods
- Bloating of abdomen
- Bowel gas
- Diarrhea
- Constipation
- Black stool
- Clay-colored stool
- Mucus in stool
- Hemorrhoids
- Rectal bleeding

YES

- Abdominal pain
- Change in diet
- Pain/burning urination
- Frequent urination
- Urination at night
- Blood in urine
- Foul odor to urine
- Low back pain
- Loss of control of urine

MEN

- Enlarged prostate
- Decreased urine stream
- Unable to interrupt stream
- Dribbling after urination
- Pus or drainage from penis
- Genital swelling/rash
- Problem with sexual function

WOMEN

- Last menstruation period _____
- Age began menstruation _____
- Age at menopause _____
- Number of pregnancies _____
- Number of live births _____
- Number of abortions/miscarriages _____
- Complication of pregnancy
- Used birth control pills
- Used IUD type: _____
- Usual length of cycle _____
- Usual length of period _____
- Change in cycle
- Spotting between periods
- Discomfort with periods
- Premenstrual tension
- Vaginal discharge
- Painful intercourse
- Itching
- Self breast examination
- Problem w/sexual function
- Lump in breast
- Abnormal pap smear
- Infertility
- Date of last pap smear _____

Please turn page. →

PERSONAL HISTORY

Current medications

List all prescriptions and non-prescriptions including dosage

Vitamin and mineral supplements

Type and dosage

Allergies

I am allergic to the following medications:

Food allergies and method of testing

Lifestyle

List your favorite foods or cravings

My sex life is satisfactory. Yes No

I do the following for relaxation/recreation: _____

I am now or have been a smoker. Yes No

How many years have you smoked? _____

How much? _____

When did you quit? _____

I estimate my use of:

Coffee: _____ cups/day Decaf: _____ cups/day

I use beer wine "hard" liquor

I consider myself a non-drinker social drinker

heavy drinker alcoholic recovering alcoholic

I use marijuana other drugs _____

I have participated in an exercise program. Yes No

I exercise on a regular basis. Yes No

_____ Times _____ Week/Month

I think this is enough exercise. Yes No

I would like to do more exercise. Yes No

I find my work too demanding boring

satisfactory very satisfying

I sleep well. Yes No

I worry about money job family life

relationships other _____

I currently see a psychotherapist or other mental health

professional. Yes No

I have had a therapeutic massage. Yes No

I currently see a chiropractor, osteopath, or other physical

therapy person. Yes No

I have been arrested. Yes No

I have been in the military service. Yes No

I have been a victim of abuse physical sexual

emotional

My spiritual life is satisfactory. Yes No

I am currently involved in a regular spiritual program

Yes No

My last physical exam was: _____