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 _____
COUNTY

Age ___ Sex ___ Height ___ ' ___ " Weight ___

_____
CITY STATE ZIP

Legal Status ☐Single ☐Married ☐Divorced ☐Separated ☐Widow/er

Phone: WORK: _____ HOME: _____

Emergency Contact Name: _____

Phone # _____ Relation: _____

Education (yrs. completed):

Elem ___ HS ___ Coll ___ Voc ___ Prof ___

If under 18, parents' name/address _____

Occupation _____

Referred by: _____ Address: _____ Retired: ☐Yes ☐No ☐Semi

e-mail Address _____

Family Physician: _____ 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	YES	RELATIONSHIP
☐ Alcohol/drug problem		☐ High blood pressure	
☐ Allergy/asthma		☐ High cholesterol/fat	
☐ Anemia		☐ Kidney disease	
☐ Arteriosclerosis		☐ Liver disease	
☐ Arthritis		☐ Mental illness	
☐ Binge eating/bulimia		☐ Obesity	
☐ Bleeding problem		☐ Stroke	
☐ Cancer		☐ Suicide	
☐ Diabetes		☐ Thyroid disease	
☐ Epilepsy/seizure		☐ Tuberculosis	
☐ Heart disease		☐ Gastro intestinal disease	
☐ Skin disease		☐ Syphilis	
☐ Endocrine/hormonal imbalance		☐ 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
☐ Acne	
☐ AIDS	
☐ Alcohol/drug problem	
☐ Allergies	
☐ Amalgams/silver fillings	
☐ Anemia	
☐ Antibiotics more than once a year	
☐ Anorexia	
☐ Anxiety	
☐ Arteriosclerosis	
☐ Arthritis	
☐ Asthma	
☐ Back pain/strain	
☐ Binge eating	
☐ Bladder infection	
☐ Blood clots	
☐ Breast lump	
☐ Bronchitis	
☐ Bulimia (self-induced vomiting)	
☐ Cancer	
☐ Cataract	
☐ Chemical sensitivity	
☐ Chicken pox	
☐ Chronic fatigue	
☐ Colds, frequent	
☐ Colitis	
☐ Congenital defect	
☐ Counseling	
☐ Depression	
☐ Diabetes	
☐ Ear infection	
☐ Eczema	
☐ Endometriosis	
☐ Epilepsy	

YES	WHEN
☐ Epstein Barr/ infectious mono	
☐ Fibrocystic breasts	
☐ Fibroids	
☐ Gallbladder problem	
☐ Glaucoma	
☐ Gonorrhea	
☐ Gout	
☐ Hay fever	
☐ Hearing problem	
☐ Heart attack	
☐ Heart failure	
☐ Heart problem	
☐ Hemorrhoids	
☐ Hepatitis	
☐ Herpes	
☐ Hiatal Hernia	
☐ High blood pressure	
☐ High cholesterol/ triglycerides	
☐ Hives	
☐ Hypoglycemia	
☐ Insomnia	
☐ Kidney infection	
☐ Kidney stones	
☐ Kidney problem	
☐ Liver disease	
☐ Menstrual problem	
☐ Mental illness	
☐ Migraine	
☐ Nervous condition	
☐ Neurological problem	
☐ Overweight (20 lbs)	
☐ Panic Attacks	
☐ Pelvic infection	
☐ Peptic ulcer	

YES	WHEN
☐ Periodontal disease	
☐ Phlebitis	
☐ Pneumonia	
☐ Premenstrual tension	
☐ Prostate problem	
☐ Psychotherapy	
☐ Reactions to	
☐ Vaccinations	
☐ Rheumatic fever	
☐ Root canal	
☐ Scarlet fever	
☐ Sexually transmitted disease	
☐ Sinusitis	
☐ Skin problem	
☐ Sleep disorder	
☐ Stroke	
☐ Suicide attempt	
☐ Syphilis	
☐ Taken steroid (cortisone/prednisone)	
☐ Thyroid problem	
☐ Tonsillitis	
☐ Tooth problems	
☐ Tuberculosis	
☐ Urine problem	
☐ Vaginitis	
☐ Vision problem	
☐ Warts	
☐ Other problems	

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

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

My sex life is satisfactory. ☐ Yes ☐ No
I do the following for relaxation/recreation: _____
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: _____