Integrative Roots Health History

This information is confidential and will not be released without written authorization.

Name_____**Age**_____

What are your health concerns? _____

_____

Allergies_____

Current Medications (include non prescription & supplements)_____

_____

_____

_____

Surgeries (include your age and/or date)_____

_____

Other hospitalizations, reason, age and/or date_____

_____

Infections (check those you have had): Hepatitis □ Rheumatic Fever □ TB □ HPV □ Pneumonia □ Herpes □ Gonorrhea □ Chlamydia □ Syphilis □ Mumps □ Chickenpox □ Measles □ Bladder or Kidney □

Medical Illness (check those you have had): High blood pressure □ Diabetes □ Heart Disease Cancer □ Arthritis □ Thyroid Disease □ Depression □ Other_____

Broken bones or serious injury_____

Immunizations (check those you have had): Pneumovax □ Influenza □ Chickenpox □ 2nd MMR □ Hepatitis B □ Hepatitis A □ HPV □ DPT □ Menactra (meningococcus) □ Polio □ Shingles □

Tetanus-did it include pertussis/whooping cough? (Last given)_____ Other_____

When did you last have these screening tests? Physical_____ Rectal (>40 yrs)_____

Colonoscopy (>50 yrs)_____ Stool Blood Cards (>50 yrs)_____ Cholesterol_____

WOMEN ONLY

Are you possibly pregnant or breastfeeding? Y N

Did your mother take hormones (DES) when pregnant with you? Uncertain Y N

Ever have an abnormal PAP smear? Y N

Age at 1st period_____ 1st day last period_____ Last PAP_____ Last Mammogram_____

Problems with periods or premenstrual symptoms?_____

Pregnancies_____ Vaginal_____ Cesarean_____ Miscarriages_____ Abortions_____

CHILDREN ONLY

Birth weight_____ Vaginal delivery or C-section?_____

Complications with pregnancy or delivery?_____

Development: At what age did child roll over_____ sit alone_____crawl_____first word_____

Water supply source (circle): City water Well Bottled water_____

How did you find out about our office? _____

Who else is on your "healing team" – other health care providers _____

Family History

	Age if Living	Age of Death	Major Illnesses, Cause of Death
Father			
Grandfather			
Grandmother			
Mother			
Grandfather			
Grandmother			
Brothers & Sisters			
Spouse			
Children			

***Check those diseases other blood relatives (aunts, uncles, cousins have had*):** cancer, diabetes, heart disease, high blood pressure, stroke, TB, thyroid disease, kidney disease, anemia, migraine, mental illness, depression, suicide, alcoholism, drug abuse, asthma, colon polyps, glaucoma, arthritis, high cholesterol, Other _____

Social and Personal History

Current occupation_____ Educational Level_____

Married, single, domestic partner_____ Partner's occupation_____

Who lives at home with you?_____

Do you have a spiritual practice from which you derive benefit? _____

Hobbies and Interests_____

Do you use tobacco or have you used it in the past? Y☐ N☐
How long?_____How much?_____
Are you happy with your weight? Y☐ N☐
Do you feel your diet is healthful? Y☐ N☐
Do you exercise regularly? What form & how often?_____ Y☐ N☐
Do you feel life is stressful? Y☐ N☐
Do you drink alcohol? If so, when was your last drink?_____ Y☐ N☐
Have you ever had a drinking problem? Y☐ N☐
Do you use marijuana or street drugs? Y☐ N☐
How many caffeine containing beverages do you average per day?_____
Have you been sexually intimate with a male partner or partners? Y☐ N☐
Have you been sexually intimate with a female partner or partners? Y☐ N☐
What type of birth control or protection do you use?_____
Have you ever had sex with someone who used IV drugs, had had many other partners, was a prostitute, gay or bisexual man, or whose needle use or sexual past was unknown to you? Y☐ N☐
Have you been exposed to harmful chemicals or radiation? Y☐ N☐
Do you wear a seatbelt? Y☐ N☐
Do you have relationship (spouse, family, friends) problems? Y☐ N☐

REVIEW OF SYSTEMS

Check those you ***now*** have or that have been ***significant*** problems in the past.

Fever or chills ☐

Weight change in past 6 months ☐

Fatigue ☐

Headaches ☐

Seizures or convulsions ☐

Fainting or passing out ☐

Dizziness ☐

Vision problems ☐

Earaches ☐

Hearing difficulties ☐

Ringing in ears ☐

Nosebleeds ☐

Sinus problems ☐

Trouble with teeth or mouth ☐

Hoarseness, prolonged ☐

Breast lump or discharge ☐

Chronic or frequent cough ☐

Coughed or vomited blood ☐

Night sweats ☐

Chest pain ☐

Palpitations ☐

Amnesia ☐

Heart murmur ☐

Swelling of ankles ☐

Nausea ☐

Jaundice ☐

Indigestion or heartburn ☐

Peptic ulcer ☐

Constipation or diarrhea ☐

Abdominal pain ☐

Bloody or tarry stools ☐

Change in size, shape, or color of bowel movement ☐

Pain or frequent urination ☐

Waking at night to urinate ☐

Control of urine ☐

Difficulty in starting urine ☐

Blood in urine ☐

Discharge from penis ☐

Sexual problems ☐

Vaginal discharge or itching ☐

Inability to have children ☐

Joint pains ☐

Kidney stones ☐

Difficulty swallowing ☐

Tremor/hands shaking ☐

Recurrent backache ☐

Leg pain when walking or at night ☐

Weakness or paralysis ☐

Numbness or tingling ☐

Sleep problems ☐

Snoring ☐

Nervousness ☐

Depression/crying spells ☐

Difficulty concentrating ☐

Memory loss ☐

Fears ☐

Disturbing thoughts ☐

Varicose veins/phlebitis ☐

Skin problems ☐

Thyroid problems ☐

Increased thirst/hunger ☐

Heat/cold intolerance ☐

Vomiting ☐

Pain in extremities ☐

Shortness of breath ☐

Burning sensation in sex organs or rectum (other than during intercourse) ☐