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 ______________________________
LAST *FIRST* *INITIAL*

Address ______________________________
COUNTY
____
CITY *STATE* *ZIP*

Phone: WORK: ______________ HOME: ______________

Emergency Contact Name: ______________

Phone # ______________ Relation: ______________

If under 18, parents' name/address ______________

Referred by: ______________ Address: ______________

Family Physician: ______________ Address: ______________

Today's Date ______________

Birth date ______________

Age ___Sex ___ Height ___ ' ___ " Weight ____

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

Education (yrs. completed):

Elem ___ HS ___ Coll ___ Voc ___ Prof ___

Occupation ______________

Retired: ☐Yes ☐No ☐Semi

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
☐ Alcohol/drug problem	
☐ Allergy/asthma	
☐ Anemia	
☐ Arteriosclerosis	
☐ Arthritis	
☐ Binge eating/bulimia	
☐ Bleeding problem	
☐ Cancer	
☐ Diabetes	
☐ Epilepsy/seizure	
☐ Heart disease	
☐ Skin disease	
☐ Endocrine/hormonal imbalance	

YES	RELATIONSHIP
☐ High blood pressure	
☐ High cholesterol/fat	
☐ Kidney disease	
☐ Liver disease	
☐ Mental illness	
☐ Obesity	
☐ Stroke	
☐ Suicide	
☐ Thyroid disease	
☐ Tuberculosis	
☐ Gastro intestinal disease	
☐ Syphilis	
☐ Gonorrhea	

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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 ___________

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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: ________