Children's Homeopathic Clinic
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Adult Health History

Name ______________________ **Date** __________ **Birthdate** __________

Date of last physical exam________ **What is your reason for today's visit?** ______________

Symptoms check (✓) symptoms you currently have or have had in the past year.

General
- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Nervousness or anxiety
- ❑ Numbness
- ❑ Sweats

Muscle/Joint/Bone
Pain, weakness or numbness in:
- ❑ Arms Hips
- ❑ Hands Feet
- ❑ Back Legs
- ❑ Neck Shoulders

Genito-urinary
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

Gastrointestinal
- ❑ Appetitive poor
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

Cardiovascular
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

Eye, Ear, Nose, Throat
- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Cold sores
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Ear Discharge
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Persistent cough
- ❑ Photophobia
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Eye infections
- ❑ Vision—flashes
- ❑ Vision—halos

Skin
- ❑ Bruise easily
- ❑ Eczema
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Psoriasis
- ❑ Rash
- ❑ Scars
- ❑ Sore that won't heal

Men only
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge/sores
- ❑ Other

Women only
- ❑ Abnormal Pap Smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other

Date of last menstrual period?__________

Date of last PAP smear?__________

Have you had a mammogram?
☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes

What form of birth control do you use?__________

Number of pregnancies? _____

Number of children?_______

Conditions check (✓) you have or have had in the past

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding disorders
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Colitis
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Irritable Bowel Disease
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate problem
- ❑ Psychiatric care
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Stroke
- ❑ Suicide attempt
- ❑ Thyroid problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Sexually Transmitted Illness
- ❑ Whooping cough

Medications and Supplements. List those you are currently taking.	**Allergies** to medications and substances.

Family History					
Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your **blood relatives** had any of the following and describe their relationship to you
Father					☐Aneurysms__________ ☐Headaches/Migraines __________
Mother					☐Anxiety__________ ☐Heart Disease__________
Brothers					☐Arthritis, gout__________ ☐High Blood Pressure________
					☐Asthma__________ ☐Kidney Disease__________
					☐Autism__________ ☐Learning Disabilities_________
					☐Bipolar Disorder__________ ☐Mental Retardation_________
Sisters					☐Brain Tumors__________ ☐Muscular Disease __________
					☐Cancer__________ ☐Obsessive Compulsive DO________
					☐Cerebral Palsy__________ ☐Schizophrenia__________
					☐Chemical Dependency__________ ☐Syphilis__________
					☐Depression__________ ☐Tics__________
					☐Epilepsy/Seizures__________ ☐Tuberculosis__________
					☐Gonorrhea__________

Health Habits check (✓) which substances you use and describe how much you use.			**Occupational Concerns** check (✓) if your work expose you to the following:	
	Caffeine			Stress
	Tobacco			Hazardous substances
	Alcohol			Heavy lifting
	Drugs			Other
	Other			

Exercise. How often and what kind of exercise do you do? ____

Serious Illness/Injuries and Hospitalizations	**Date**	**Outcome**	**Pregnancy History** Year/Date of birth	**Complications if any.**

Preferences, habits, and particulars

Food

Which foods do you crave?

☐Sweet ☐Sour ☐Salty ☐Fats ☐Breads

Appetite**?** ☐Good ☐Fair ☐Poor

Thirst? ☐Very thirsty ☐Medium ☐Not at all

Sleep Habits

Bed time? __________

Wake time? __________

Time to fall asleep? __________

Sleep position? __________

During sleep do you:

☐Grind teeth ☐Snore

☐Perspire ☐Walk

☐Talk ☐Have nightmares?

☐Wake at night? Time__________

Fears

☐Claustrophobia ☐Dark

☐Heights ☐Flying

☐Thunder/Lightning ☐Water

☐Animals. Which ones? ____________ ☐Other_____________

Temperature

Sense of body temperature? ☐Chilly ☐Warm

Hands? ☐Chilly ☐Warm

Feet? ☐Chilly ☐Warm

Other

Do you bite your nails? ☐Yes ☐No

Favorite book or movie?

Best time of day? _______ Worst time of day? _______

Do you recall your dreams? ☐Yes ☐No

Preferred Climate ☐temperate ☐desert ☐mountain ☐seashore

Most significant person in your life and why ____

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