

**BODYWISE MEDICINE**  
**Personal Health History**

**Demographic Information**

|   |     |                             |                     |                               |                     |
|---|-----|-----------------------------|---------------------|-------------------------------|---------------------|
| Name (last, first, MI)                          |     |                             | Social Security No. |                               | Birth Date          |
| Age   | Sex | Marital Status<br>M / S / D | Home Phone<br>(   ) |                               | Work Phone<br>(   ) |
| Home Address (street, city, state and zip code) |     |                             | Cell Phone<br>(   ) |                               |                     |
|   |     |                             | Email Address       |                               |                     |
| Employer  |     |                             | Job Title           |                               |                     |
| Emergency Contact (Name)                        |     | Contact (Phone)             |                     | Who referred you?             |                     |
| Personal Physician (Name and Address)           |     |                             |                     | Preferred Pharmacy Name/Phone |                     |
| Office Phone:                                   |     |                             |                     |                               |                     |

**History**

**This section is for the purpose of learning more about your health history. Please read and answer all of the following questions to the best of your knowledge.**

**Reason for Consultation**

**What health concern and symptoms brings you to the clinic?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

What would you most like to achieve with this health consultation? \_\_\_\_\_

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Are you currently under the care of a physician or health professional for a medical/health condition?  Yes  No

If yes, please list condition(s): \_\_\_\_\_

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### ***Past Medical History***

*Please check any medical conditions or health problems that you currently have or have had in the past?*

- |                                  |  |                           |  |
|----------------------------------|--|---------------------------|--|
| Headaches (Migraines, other)     | <input type="radio"/> yes <input type="radio"/> no | Heart Disease             | <input type="radio"/> yes <input type="radio"/> no |
| Seizures Disorder                | <input type="radio"/> yes <input type="radio"/> no | Chest Pain                | <input type="radio"/> yes <input type="radio"/> no |
| Recurrent sinus infections       | <input type="radio"/> yes <input type="radio"/> no | Irregular Heart Beat      | <input type="radio"/> yes <input type="radio"/> no |
| Seasonal allergies               | <input type="radio"/> yes <input type="radio"/> no | High Blood Pressure       | <input type="radio"/> yes <input type="radio"/> no |
| Psychiatric or Emotional Illness | <input type="radio"/> yes <input type="radio"/> no | Blood Clotting problems   | <input type="radio"/> yes <input type="radio"/> no |
| Depression                       | <input type="radio"/> yes <input type="radio"/> no | Bleeding disorder         | <input type="radio"/> yes <input type="radio"/> no |
| Anxiety or excessive stress      | <input type="radio"/> yes <input type="radio"/> no | Stroke/vascular disease   | <input type="radio"/> yes <input type="radio"/> no |
| Asthma                           | <input type="radio"/> yes <input type="radio"/> no | Constipation/diarrhea     | <input type="radio"/> yes <input type="radio"/> no |
| Chronic bronchitis               | <input type="radio"/> yes <input type="radio"/> no | Hepatitis/Liver disease   | <input type="radio"/> yes <input type="radio"/> no |
| Lung or breathing problems       | <input type="radio"/> yes <input type="radio"/> no | Kidney disease            | <input type="radio"/> yes <input type="radio"/> no |
| Chronic Indigestion              | <input type="radio"/> yes <input type="radio"/> no | Menstrual disorders       | <input type="radio"/> yes <input type="radio"/> no |
| Stomach Ulcers                   | <input type="radio"/> yes <input type="radio"/> no | Reproductive problems     | <input type="radio"/> yes <input type="radio"/> no |
| Intestinal Disease               | <input type="radio"/> yes <input type="radio"/> no | Prostate problems         | <input type="radio"/> yes <input type="radio"/> no |
| Skin problems/dermatitis         | <input type="radio"/> yes <input type="radio"/> no | Sexual/Libido problems    | <input type="radio"/> yes <input type="radio"/> no |
| Back Pain or Sciatica            | <input type="radio"/> yes <input type="radio"/> no | Tendonitis                | <input type="radio"/> yes <input type="radio"/> no |
| Herniated Disc                   | <input type="radio"/> yes <input type="radio"/> no | Chronic pain problems     | <input type="radio"/> yes <input type="radio"/> no |
| Neck pain                        | <input type="radio"/> yes <input type="radio"/> no | Shoulder problems         | <input type="radio"/> yes <input type="radio"/> no |
| Chronic Muscle or Joint Pain     | <input type="radio"/> yes <input type="radio"/> no | Osteoarthritis            | <input type="radio"/> yes <input type="radio"/> no |
| Carpal Tunnel Syndrome           | <input type="radio"/> yes <input type="radio"/> no | Rheumatoid Arthritis      | <input type="radio"/> yes <input type="radio"/> no |
| Fibromyalgia                     | <input type="radio"/> yes <input type="radio"/> no | Artificial joint/implants | <input type="radio"/> yes <input type="radio"/> no |
| Diabetes                         | <input type="radio"/> yes <input type="radio"/> no | Cancer                    | <input type="radio"/> yes <input type="radio"/> no |
| Thyroid disease                  | <input type="radio"/> yes <input type="radio"/> no | Psoriasis or eczema       | <input type="radio"/> yes <input type="radio"/> no |
| Osteoporosis/Osteopenia          | <input type="radio"/> yes <input type="radio"/> no |                           |  |

List any additional health problems not listed above: \_\_\_\_\_

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

List any surgeries/operations you have had, and when: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any medications you are currently taking (or have taken in the recent past)

| Medication Name | Date Started | Date Stopped | Dosage (amt/# daily) |
|-----------------|--------------|--------------|----------------------|
|                 |              |              |                      |
|                 |              |              |                      |
|                 |              |              |                      |
|                 |              |              |                      |

*(If any additional medications please attached a separate page list the above info)*

Nutritional supplements, vitamins, herbs, homeopathic remedies taken: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medication Allergies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Environmental/Food Allergies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Preventive Tests:**                      *Month/Year of last test*                      *Test Results (if known)*

Cholesterol                                      \_\_\_\_\_                                      \_\_\_\_\_

Bone density                                      \_\_\_\_\_                                      \_\_\_\_\_

Colonoscopy                                      \_\_\_\_\_                                      \_\_\_\_\_

Exercise stress test                                      \_\_\_\_\_                                      \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Family History** (Write the relationship of the relative(s) with the disease on the adjacent lines)

Heart Disease             yes  no            \_\_\_\_\_

High Blood Pressure     yes  no            \_\_\_\_\_

Diabetes                  yes  no            \_\_\_\_\_

Arthritis                 yes  no            \_\_\_\_\_

Skin disorders            yes  no            \_\_\_\_\_

Breast Cancer            yes  no            \_\_\_\_\_

Uterine/Ovarian Cancer  yes  no            \_\_\_\_\_

Prostate Cancer         yes  no            \_\_\_\_\_

Colon Cancer            yes  no            \_\_\_\_\_

Other Cancer             yes  no            \_\_\_\_\_

List any other disease/condition in the family and relationship? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WOMEN**

ARE YOU PREGNANT?  yes  no    First day of last menstrual cycle \_\_\_\_\_

Date of last pap/pelvic/breast exam \_\_\_\_\_ Results:  normal  abnormal

Date of last mammogram \_\_\_\_\_ Results:  normal  abnormal

Do you perform monthly self breast exams  yes  no

Are you currently taking or have you in the past taken hormones or oral contraceptives  yes  no

If yes, please list all hormones and oral contraceptives you have taken and when \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Have you ever had any problems or concerns about taking hormone replacement therapy?

yes  no

If yes please list problem: \_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_ How many children? \_\_\_\_\_

Have you had a hysterectomy?  yes  no If yes, were your ovaries removed?  yes  no

Have you had any menstrual irregularities?  yes  no (if yes explain) \_\_\_\_\_

Has your abdominal girth and weight been increasing?  yes  no

### **MEN**

Date of last prostate exam: \_\_\_\_\_

Are you concerned with loss of muscle mass, tone, or strength?  yes  no

Have you had problems with urination (decreased stream, frequent night urination)  yes  no

Do you perform periodic testicular self examination?  yes  no

Has your abdominal girth and weight been increasing?  yes  no

### ***Social History and Personal Health Habits***

#### ➤ **General** (Check all that apply)

My health is  excellent  good  fair  poor.

My physical fitness is  excellent  good  fair  poor

I am under a lot of stress  I am fatigued all the time  I am having difficulty dealing with stress  I practice meditation or other relaxation techniques  I am often sad and blue

#### ➤ **Dietary Habits**

No special diet habits  Avoids red meat  Minimizes fat  Minimizes Carbs  
 Vegetarian

Emphasize fruits, grains and vegetables  I try to eat a healthy diet

I do not eat dairy/cheese  I commonly eat at fast food restaurants

I commonly consume:  Coffee  Regular soft drinks  Diet soda  Candy/chocolate  
 Chips/crackers

#### ➤ **Exercise Habits**

No special exercise habits  I routinely exercise \_\_\_\_\_hr(s) \_\_\_\_\_X/week

Aerobic exercise (jog/walk/treadmill)  Lift weights  Swim

Stretch/Yoga/Tai Chi/Chi Gong

Other \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

➤ **Tobacco Use**

- I never smoked cigarettes or chewed tobacco
- I now smoke \_\_\_\_\_ packs of cigarettes per day. I have smoked for \_\_\_\_\_ years
- I quit smoking in \_\_\_\_\_ (mo/yr). I smoked \_\_\_\_\_ packs/day for \_\_\_\_\_ years
- I smoke cigars/pipe

➤ **Alcohol Use**

- I never drink alcohol       I drink occasionally or socially
- I regularly drink:     1-2 drinks/day     more than 2 drinks/day     more than 4 drinks/day

➤ **Hobbies/Sports/Recreation**

List routine hobbies/sports/recreational activities: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature**

\_\_\_\_\_  
\_\_\_\_\_

**Date**

A 24 hour notice of cancellation is required. If your cancellation is less than 24 hours or you do not show for your appointment a rescheduling fee will apply before for your next appointment. This is for the consideration of our patients that are waiting for a sooner appointment and allows us the necessary time to contact them with the sooner appointment availability. We thank you for understanding regarding this policy that has proven to be very successful in meeting our patient's medical needs.

**Practitioner comments on above:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_