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Comprehensive Health History

Name:_____**Today's Date:**_____
Date of Birth: _____ **Age**:_____ **Height**:_____**Weight**:_____**Marital Status**:_____
Physician:_____
Diagnoses:_____

Brief description of current health issue:_____
_____

List all health problems you are being treated for:_____
_____
_____

Diagnostic tests and outcomes (DEXA scan, blood work, stool analysis, etc) _____
_____
_____

Major hospitalizations/surgeries/injuries:_____
_____
_____

Medications:_____
_____
_____

Vitamins and nutritional supplements:_____
_____
_____

Medical History:

- ☐ Allergies/sinus issues
- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Cancer
- ☐ Chronic Fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Colitis/IBD/IBS
- ☐ Dental problems
- ☐ Depression/ anxiety
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder, now or youth
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Ears, nose, throat issues
- ☐ Fibromyalgia
- ☐ Food intolerances
- ☐ GERD/ indigestion
- ☐ Heart disease
- ☐ Migraine headaches
- ☐ Neurological problems
- ☐ Thyroid disease
- ☐ Osteoporosis
- ☐ Seasonal affective disorder
- ☐ Skin problems

Digestive Health: Uncovering any digestive issues is critical to bone health. Though this is just a short screening tool, it can help to determine if you have a digestive issue that is interfering with digestion and absorption of nutrients necessary for maintaining and building bone.

For the next set of questions, enter the number that best describes the intensity of your symptoms:

0 = symptom is not present/rarely present
1 = Mild/sometimes
2 = Moderate/often
3 = Severe/almost always there

Stomach: Hypoacidity

1. Burping ☐
2. Fullness for extended time after meals ☐
3. Bloating ☐
4. Poor appetite ☐
5. Stomach upsets easily ☐
6. History of constipation ☐
7. Known food allergy ☐
8. Iron deficiency anemia ☐
9. Nausea after taking supplements ☐
10. Heartburn/indigestion ☐

Small intestine: Hypofunction

1. Abdominal cramps ☐
2. Indigestion 1-3 hours after eating ☐
3. Fatigue after eating ☐
4. Gas ☐
5. Alternating constipation and diarrhea ☐
6. Lose stools ☐
7. Roughage/fiber cause constipation ☐
8. History of gallstones/gallbadder disease ☐
9. Undigested food in stool ☐
10. Mucus in stools ☐
11. Shiny stool ☐
12. Dry, flaky skin or dry, brittle hair ☐
13. Nausea ☐

History of antibiotic use: Yes: ☐ No: ☐ History of yeast infections: Yes: ☐ No: ☐

Stress and sleep habits: Circle the level of stress you are experiencing on a scale of 1-10
(1 being the lowest, 10 highest): 1 2 3 4 5 6 7 8 9 10
What are your major causes of stress? _____
_____
How many hours of sleep do you typically get at night?_____
What time do you go to bed?_____ What time do you wake up?_____
Do you wake in the middle of the night?_____ What time/for what reason?_____

Health Habits:

☐ Tobacco: Cigarettes: #/day_____
☐ Alcohol:
Wine: # glasses/d or wk_____
Liquor: # ounces/d or wk_____
Beer: # glasses/d or wk_____
☐ Caffeine:
Coffee: # 6 oz cups/d_____
Tea: #6 oz cups/d_____
☐ Soda: # cans/d_____
☐ Water: # glasses/d_____

Exercise

☐ 5-7 days/ wk ☐ 3-4 days/wk ☐ 1-2 days/wk
☐ 45 min or more in duration
☐ 30-45 min in duration
☐ Less than 30 min duration
☐ Walk_____
☐ Jog, aerobics, impact exercises_____
☐ Bicycle, swim non-impact exercises_____
☐ Weight lifting
☐ Pilates
☐ Yoga