Institute for Integral Health
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Today's Date: _____
Name: _____ Age: _____ Sex: M F DOB: _____
Address: _____
City_____ State: _____ Zip_____
Telephone: Home _____ Cell_____ Work_____
May we contact you by mail? Y N Phone? Y N Voice Message ok? _____
Email address: _____
Emergency Contact: _____
May we share medical information? _____ If so, Name_____
Current Primary Physician_____
Referred by _____

Medical Information

Main Reason for your visit: _____
_____
_____

Details of any present condition: _____
_____
_____

Current Medications and Dosages: _____
_____
_____
_____

Over the Counter Supplements/Herbs/Vitamins (please be specific) _____
_____
_____
_____
_____

Please Circle anything that applies:

Allergies: No known drug allergies - Penicillin - Sulfa - Codeine - Aspirin - Bee Stings Food Allergies - Seasonal Allergies - Other:_____

+Head, Ears, Eyes, Nose and Throat (HEENT)

Ear pain - Ear infection - Hearing Loss - Tinnitus(ringing in ears) - Dizziness - Vertigo Double vision - Tunnel vision - Glaucoma - Cataracts - Eye pain - Blurriness - Glasses Contacts Epistaxis (nose bleeds) - Rhinitis (inflammation of mucous membranes that line the nose) Sinusitis (inflammation of mucous membranes lining facial tissues) - TMJ dysfunction (jaw joint) Dysphagia (swallowing difficulty) - Vocal cord polyps (lumps) - Dentures - Hoarseness Sore throat - Neck pain - Neck masses

Other HEENT Problems: _____

Rheumatic:

Systemic lupus - Erythematosus - Rheumatoid Arthritis - Scleroderma - Raynaud's Phenomena Temporal Arteritis - Other:_____

Cardiovascular: Heart

Myocardial infarction (heart attack) - Valvular heart disease (valves to the heart have disease) Pulmonary hypertension (high pressure in the arteries of the lungs) - Hypertension (high blood pressure)Angina pectoris (chest pain) - Cardiac Arrhythmia (abnormal heart beat or rate) Congestive heart failure (heart failure) - Carotid stenosis (hardening of the carotid arteries) PVD-Peripheral vascular disease (narrowing of blood vessels of the legs and arms) Claudication (Limping due to blockage of the arteries of the lower legs)

Other Heart problems:_____

Pulmonary:(Lung Problems)

Asthma - Bronchitis Pneumonia - COPD (Chronic Obstructive Pulmonary Lung Disease) Pulmonary Sarcoidosis - Tuberculosis - Lung pain - Lung masses - Respiratory failure Cancer - Pneumothorax (presence of air or gas in the lining surrounding the lung causing pain)

Other Lung Problems:_____

Gastroenterology: Stomach/abdomen

Frequent; Nausea, emesis, diarrhea or constipation. - Gastroesophageal reflux disease Peptic ulcer disease - Jaundice (yellowing of the skin and eyes) - Hepatitis (liver inflammation) Appendicitis (pain and inflammation of the appendix) - Melena (Black stool caused by bleeding) Colon polyps (masses in the colon) - Diverticulosis/Diverticulitis (protrusions of the bowel) cholecystitis/Gallstone disease (inflammation or disease of the pancreas)

Other: _____

Kidney: Renal/Urinary

UTI (inflammation of the urinary bladder or urethra) - Prostatitis (inflammation of the prostate) Kidney failure - Hydronephrosis (fluid filled enlargement of the kidney) - Kidney stones Cystitis (inflammation of the urinary bladder or urethra) - Polycystic kidney disease Orchitis (inflammation of one or both testicles) - Vasectomy

BPH (a condition where benign (non-cancerous) nodules enlarge the prostate gland)
Other Renal/Urinary_____

Musculoskeletal and Extremities:

Arthritis – Gout - Generalized Muscle weakness - Muscle Weakness - Edema(swelling)
Extremity numbing/tingling/carpal tunnel syndrome
Fractures Y N what body part_____ Left or Right_____
Other: _____

Oncological: (Cancer)

Brain Cancer - Skin Cancer: Melanoma - Squamous cell Carcinoma - Basal Cell Carcinoma
Throat Cancer - Stomach Cancer - Liver Cancer - Pancreatic Cancer - Colon Cancer
Bladder Cancer - Ovarian Cancer - Uterine Cancer - Cervical Cancer - Testicular Cancer
Kidney Cancer - Other:_____

Endocrine System: (glands in the body which secrete hormones)

Hypoglycemia (low blood sugar) - IDDM (Insulin dependent diabetes)
Cushing's disease(Excess production of a hormone of the pituitary gland)
Hypothyroidism (not enough thyroid hormones) - Hyperthyroidism (too much thyroid hormone)
Addison's disease (a wasting disease caused by underactive of the adrenal glands)
NIDDM (non-insulin dependent diabetes) Other: _____

Neurological: (Disease of the nervous system)

CVA-Stroke - TIA Seizure disorder - Migraines - Cluster Headache - Parkinson's Disease
Cranial nerve dysfunction - Other:_____

Psychological History: (related to the mind and mental process)

Depression - Anxiety disorder - Mood disorder - Anger disorder - Panic disorder - Dementia
Schizophrenia - Post-traumatic stress disorder - Borderline personality
Other:_____

Past Surgical History:

Thyroidectomy _____	Date_____	Bronchoscopy _____	Date_____
Tonsillectomy _____	Date_____	Lung resection R/L ___	Date_____
Sigmoidoscopy___	Date_____	Angiogrpaphy____	Date_____
Valve Replacement____	Date_____	Angioplasty_____	Date_____
Endoscopy_____	Date_____	Gastric Surgery___	Date_____
Pacemaker_____	Date_____	Appendectomy_____	Date_____
D & C____	Date_____		

Total abdominal hysterectomy and removal of ovaries_____ Date_____
Hip replacement _____ R or L_____ Date:_____
Other Surgical Procedures and Dates: _____

Family History: **Please tell me mother, father, brother, aunt, uncle, grandparent etc:**

ILLINESS	RELATIONSHIP	ILLINESS	RELATIONSHIP
alcoholism/drug abuse	_____	Alzheimer's Disease	_____
asthma	_____	breast cancer	_____
cancer (_____)	_____	depression	_____
diabetes	_____	heart attack	_____
high cholesterol	_____	high blood pressure	_____
osteoporosis	_____	stroke	_____
thyroid	_____		

autoimmune disease such as lupus or rheumatoid arthritis _____

Personal History:

Immunizations____ Up to date?_____ HIV Status?_____

Do you smoke tobacco? Y N If yes, how much per day? _____ How many years? _____

Do you smoke marijuana Y N If yes, how much per day? _____ How many Years? _____

Do you drink alcohol? Y N If yes, how many per day/week_____

Caffeine intake? Coffee/Tea _____ how many per day_____

How many carbonated drinks per day? _____

Do you use recreational drugs? Y N

If yes, has someone close to you expressed concern regarding your use in drinking or drugs? Y N

Do you feel safe in your home? Y N Do you feel safe in your relationship? Y N

Past diet nutrition and food intake history:

Dietary Education: Self Registered Dietician

Diet Program: Weight watchers - Jenny Craig - South Beach Diet - Atkins - Grapefruit - Paleo

Have you used medication to lose weight? Y N if so, what medications_____

Are you Gluten Free? Y N if so why_____

Are you Dairy Free? Y N if so why_____

Have you ever been treated for an eating disorder? Y N

Exercise History:

Do you exercise? Y N

Do you have any conditions that prevent you from exercise? _____

_____

What types of exercise do you enjoy? _____

_____

How often do you workout per day/per week? _____