FAMILY TO FAMILY
Your Home for Whole Health Care

REASON FOR VISIT: Please list the topics you would like to discuss with your physician in your upcoming visit.

CURRENT HEALTH HISTORY

Please list any new health problems since your last visit. Include

- when you first became aware of this concern and describe what else was happening in your life the year beforehand.
- A list of the health professionals you currently see for this and what tests and current treatments you are using.
- A list of who you have seen in the past, what tests you have had, treatments you have tried. What has or hasn't been helpful.
- Describe how this affects your daily life, what makes it worse and better.
- Any additional history about this concern.

Name your Concern/ Date onset
Detail: _____

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Detail: _____

MEDICATION AND SUPPLEMENTS

Current Medications: List everything you take. Include Name/Strength/Direction/Who prescribes it/ What its for.

Current Supplements: List everything you take. Include Name/Strength/Direction/Who prescribes it/ What its for.

REVIEW OF SYSTEMS that apply to you CURRENTLY

Any changes in your health since you were last seen?

No/Yes

Detail:

GENERAL

Recent Weight Loss - Y/N

Weight Gain – Y/N

Night Sweats – Y/N

Fatigue unexplained – Y/N

Fatigue with exertion – Y/N

Swollen glands – Y/N

Low body temperature – Y/N

Intolerant of Heat – Y/N

Intolerant of Cold – Y/N

Excessive Thirst – Y/N

SKIN * HAIR * NAILS

Rashes that is of concern– Y/N

Moles that are of concern – Y/N

Other skin lesions that are of concern – Y/N

Bumps on back of arms – Y/N

Easy bruising – Y/N

Sweating, excess – Y/N

Hives – Y/N

Dandruff – Y/N

Dry Skin – Y/N

Cracking or peeling skin – Y/N

Eczema – Y/N

Sensitivity to bug bites – Y/N

Sensitivity to poison ivy/oak – Y/N

Shingles/herpes – Y/N

Strong body odor – Y/N

Athlete's foot/jock itch – Y/N

Lack of pigment – Y/N

Acne – Y/N

Hair Loss – Y/N
Hair excess – Y/N
Premature graying – Y/N
Nail issues – Y/N

EYES
Change in eyesight – Y/N
Eye pain – Y/N
Crusting of lids – Y/N
Dark circles under eyes – Y/N
Itching of eyes – Y/N

EARS
Ringing – Y/N
Hearing loss – Y/N
Ear pain – Y/N
Ear Wax excessive – Y/N

Sensitivity to sound – Y/N

NOSE * SINUS
Frequent Colds – Y/N
Nose Bleeds – Y/N
Sneezing excessively – Y/N
Nasal Congestion – Y/N
Sinus Pressure or Pain – Y/N
Loss of or distorted sense of smell – Y/N

MOUTH * THROAT
Frequent Cavities – Y/N
Floss daily – Y/N
Silver Mercury Fillings – Y/N
Dentures – Y/N
Tooth Pain – Y/N
Gum problems – Y/N
Loss or Distorted sense of taste – Y/N

Bad breath – Y/N
Dry mouth – Y/N
Cracking in corners of lips – Y/N
Swollen tongue or lips – Y/N
Sore Throat – Y/N
Jaw click – Y/N
Teeth clenching – Y/N
Canker Sores – Y/N
Cold Sores – Y/N
Hoarseness – Y/N
Fullness in throat – Y/N

NECK
Neck Pain – Y/N
Neck Stiffness – Y/N
Swollen lymph glands – Y/N
Enlarged thyroid gland – Y/N

BREAST
Pain – Y/N
Lumps – Y/N
Nipple Discharge – Y/N
Cysts – Y/N

RESPIRATORY
Shortness of breath – Y/N
Wheezing – Y/N
Recurrent Infections – Y/N
Cough – Y/N
Phlegm – Y/N

CARDIOVASCULAR
Chest pain at rest – Y/N
Chest pain with exertion – Y/N
Swelling of ankles or legs – Y/N
Irregular Heart Beats – Y/N

Heart racing or palpitations – Y/N
Fainting Spells – Y/N
Sleep with extra pillows to breath – Y/N
Leg pain with exercise – Y/N
Leg pain at rest – Y/N
Cold hands or feet – Y/N
Varicose veins – Y/N
Leg Cramps – Y/N

DIGESTION

Poor Appetite – Y/N
Excessive Hunger – Y/N
Food Allergies or sensitivities – Y/N
Difficulty chewing – Y/N
Difficulty swallowing – Y/N
Nausea – Y/N
Vomiting – Y/N
Heartburn – Y/N
Regurgitation – Y/N
Reflux – Y/N
Indigestion – Y/N
Cramping/ Bloating after eating – Y/N
Flatus/Gas/Burping – Y/N
Upper Abdominal Pain – Y/N
Lower Abdominal Pain – Y/N
Straining to have bowel movement – Y/N
# of stools/day_____
Loose stools – Y/N
Hard stools – Y/N
Infrequent stools < 1/day – Y/N
Bloody Stools – Y/N
Black Stools – Y/N
Abnormal appearance of stools – Y/N
Hemorrhoids – Y/N
Rectal Pain or itching – Y/N
Do you feel you digest your food well – Y/N

URINARY

Frequency – Y/N

Pain – Y/N

Burning – Y/N

Urgency – Y/N

Difficulty starting or stopping stream – Y/N

Leakage of urine – Y/N

Wake up to urinate – Y/N

REPRODUCTIVE WOMEN

Date of Last Menstrual Period _____

Regular Menstrual cycle– Y/N

Irregular Menstrual cycle – Y/N

Pain with Menses – Y/N

Heavy flow – Y/N

Minimal flow – Y/N

Menopause – Y/N

Hot flashes – Y/N

Vaginal dryness – Y/N

Vaginal itching – Y/N

Abnormal discharge – Y/N

Vaginal pain – Y/N

Pelvic pain – Y/N

Pain with intercourse – Y/N

Satisfied with Sex life – Y/N

Difficulty getting pregnant – Y/N

PMS symptoms – Y/N

- Constipation – Y/N
- Swelling – Y/N
- Moodiness – Y/N
- Depression – Y/N
- Irritability – Y/N
- Sore breast – Y/N
- Sugar cravings – Y/N

REPRODUCTION MEN

Penile discharge – Y/N

Scrotum pain/ lumps – Y/N

Loss of erection – Y/N

Ejaculation problems – Y/N

Prostate problems – Y/N

Satisfied with Sex life – Y/N

NEUROLOGIC

Headaches – Y/N

Seizures – Y/N

Fogginess – Y/N

Difficulty concentrating – Y/N

Poor memory – Y/N

Trouble finding words – Y/N

Trouble thinking – Y/N

Trouble with balance – Y/N

Tremors/ Shakiness – Y/N

Loss of sensation/ numbness – Y/N

Restless legs – Y/N

Dizziness - fainting or almost fainting – Y/N

Dizziness - spinning or vertigo – Y/N

MUSCULOSKELETAL

Muscle weakness – Y/N

Location _____

Muscle cramps or pain – Y/N

Location _____

Tendonitis – Y/N

Location _____

Joint Pain/ Stiffness/ Swelling – Y/N

Location _____

Back Trouble – Y/N

Location _____

PSYCHOLOGICAL

Nervousness – Y/N

Anxious – Y/N

Panic – Y/N

Excess worry – Y/N

Stress – Y/N

Grief – Y/N

Depression – Y/N

Manic– Y/N

Irritability – Y/N

Thoughts of Suicide – Y/N

PTSD – Y/N

Marital/Relationship problems – Y/N

Agoraphobia – Y/N

Hallucinations – Y/N

Other phobias – Y/N

OCD – Y/N

LIFESTYLE

Are your ready or willing to make changes in your lifestyle ? Yes/No/Maybe
What kind of changes have you been considering, if any?

FOOD AND NUTRITION

The most important thing I need to change about my diet to improve my health is:
Do you avoid any foods?

Briefly describe your dietary habits (Include food sensitivities, vegetarian, vegan, gluten-free, etc.):

Diet (Typical day)

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

Is your weight a concern to you – Y/N

Current Weight:
Desired Weight:
Highest Weight:

Lowest Weight:
Height:

SUBSTANCES (coffee, alcohol, tobacco, sugar, pot, other)

Update:

EXERCISE - Type and Frequency

Update:

SLEEP/REST
Update:

PSYCHOLOGICAL/SPIRITUAL

- Please say something about your beliefs or spiritual orientation:
- What are you doing for Fun?
- What brings you joy?
- Do you feel more vital than you did the last time you were seen? Y/N
- Current Stressors ?
- Do you have a Centering Practice : Y/N?
- Do you currently feel safe: Y/N?
- Any significant Losses: Y/N?
- Any significant Trauma: Y/N?
- Any noteworthy Triumphs: Y/N?

PAST MEDICAL HISTORY

DIAGNOSTIC SCREENING TESTS (Date and result)
Update:

EXPOSURES: list any new occupational and environmental exposures

IMMUNIZATIONS (Enter date of vaccination)
Update:

IF YOU ARE WILLING: PLEASE CREATE A TIME LINE OF ALL MEDICAL PROBLEMS, HOSPITALIZATIONS, SURGERIES, INJURIES AND MAJOR LIFE EVENTS NOT LISTED IN THE CURRENT CONCERNS. BEGIN FROM THE TIME YOU WERE IN THE WOMB.
Please list, include date of onset, your age and any relevant detail such as tests, treatment and impact on your life positively or negatively.

FAMILY HEALTH HISTORY

List all health issues of your family members. Include current age, and if s/he is alive or deceased. (For example; heart disease, stroke, cancer, diabetes, digestive issues, dementia/neurologic illnesses, lung dz, hormonal imbalance, auto-immune illness, spinal/muscular problems, developmental problems, depression, anxiety, PTSD)

Mother:
Father:
Adoptive parents:
Paternal GF:
Paternal GM:
Maternal GF:
Maternal GM:
Aunts/Uncles:
Siblings (include names):
Other:

SOCIAL HISTORY

RELATIONSHIPS: Update
Current Living Situation:
Current Partner :
Pets:

EDUCATION
Updates:

EMPLOYMENT
Updates:

ADDITIONAL LIFE STORY – not previously described or listed
Updates: