PATHWAYS
TO NATURAL HEALTH, INC.

DATE _____

HEALTH HISTORY SUMMARY

Name: _____ Age: _____ Birthdate: _____ Blood Type: _____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ Work Phone: _____

Email: _____ Marital Status: _____ # of Children: _____

In case of emergency: _____ Relationship: _____ Tel: _____

Whom can we thank for this referral? _____

List your most important health issues and length of time they have been going on:

1)_____

2)_____

3)_____

4)_____

5)_____

List any diagnosed medical conditions (for ex: hypertension, cardiovascular disease)?

1) _____ Length of time: _____

2) _____ Length of time: _____

3) _____ Length of time: _____

4) _____ Length of time: _____

Current medications, including hormones (pls give name, dosage, and length of time taking it)

_____

_____

_____

_____

Allergies to Medications?_____

Sensitivities to Foods? Herbs? Vitamins? _____

Environment or chemicals? _____

Vitamins/Herbs/Supplements (please give name, dosage and how long you have been taking it)

_____

_____

_____

Your Health History

The general state of your health is: excellent ____ good _____ average _____ fair _____ poor _____

Your energy level is (1 to 10 with 10 as highest) _____ What time of day is it the best? _____

The worst? _____ Weight _____ Height _____ Any change in either in the past year? _____

Current physicians: _____

_____

Other health care providers: _____

_____

Are you currently working with a counselor, psychologist, social worker, pastor or other therapist?

For how long? _____ Have you in the past? _____ If so, when? _____

What childhood illnesses have you had?

Measles ____	Mumps _____	Chickenpox _____	Whooping Cough ____
Polio _____	Diphtheria _____	Rheumatic Fever _____	Scarlet Fever _____
Smallpox _____	Typhoid Fever _____	Tuberculosis _____	Mono _____

What surgeries, hospitalizations, X rays, CT scans, EEGs and EKGs have you had and dates:

_____

_____

_____

Which of the following have you had? What year?

Allergies _____	Anemia _____	Asthma _____
Diabetes _____	Ear Infections _____	Eczema_____
High Blood Pressure _____	Hepatitis _____	Herpes_____
High cholesterol_____	Tonsillitis_____	Thyroid problems _____

Sexually transmitted infections _____ Frequent use of antibiotics _____

Which of the following do you currently use? How much, how often, how long?

Alcohol _____ Tobacco/E-Cig _____

Hormones _____ Coffee/Tea _____

Cortisone _____ Laxatives _____

Sedatives _____ Antacids _____

Other recreational drugs _____

Family History

Has any blood relative had any of the following?

Allergies _____ Anemia ____ Arthritis _____ Asthma/Hives/ Hay fever _____ Cancer _____

Cardiovascular disease _____ Cataracts _____ Depression ____ Diabetes _____ Addiction____

High blood pressure _____ Skin disease _____ Epilepsy or seizures _____ Stroke _____ Thyroid_____

Mental illness_____ Other relavant family history _____

_____

_____

Please list age, health conditions, and causes of death, if appropriate

	Age	Health Conditions	Deceased (age)	Cause of death
Mother				
Father				
Brother				
Sister				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

What is your family heritage? Please list all backgrounds and give approximate percentage

_____

Lifestyle

Live with: Spouse _____ Partner _____ Parents _____ Children _____ Friends _____ Alone _____

Are you currently in a happy, satisfying relationship with someone?

Very much *Mostly* *Somewhat* *Not at all* *Not Currently in Relationship.*

What is your current level of education? _____ Are you satisfied with this? _____

Occupation: _____Hours per week _____

Do you enjoy your work? _____ Do you take vacations? _____

What do you enjoy most in your life? _____

Do you exercise? _____ If yes, what type and how minutes per day? _____

Do you have a religious or spiritual practice? _____ If yes, what? _____

What time do you fall asleep? _____ Wake up? _____ How many hours of sleep do you get a night? _____ Do you have problems falling asleep or staying asleep? _____ How would you rate the quality of your sleep (with 10 being excellent)?_____ Do you wake feeling refreshed? _____

What do you worry about?

_____

_____

_____

Do you have: Anxiety _____ Stress _____ Depression_____ Mood Swings_____

Please list significant stressful events in your life:

1) _____ Date: _____

2) _____ Date: _____

3) _____ Date: _____

Gastrointestinal

Do you have any problems with gas, bloating, or fullness after eating? _____ How often? _____

How severe? _____ How long have you had this? _____ How many bowel movements a day? _____ Do you have *blood mucus undigested food* or any black stool? _____

Any rectal itching? _____ Do your stools tend to be formed or loose? _____ How often do you have diarrhea? _____ Do you ever have alternating constipation and diarrhea? _____

How often? _____ Do you ever have long, thin stools? _____ How often do you have small and hard stools? _____ Do you ever have yellow or light colored stools? _____ How often? _____ How often do your stools have a strong disagreeable odor? _____

Typical Breakfast_____

Typical Lunch _____

Typical Dinner _____

Typical Snacks _____

Cardiac/Respiratory

Have you ever been diagnosed with a heart condition? _____ Do you get heart palpitations? _____ How often and how long do they last? _____ Does your blood pressure run low or high? _____ Do you have a heart murmur or arrhythmia? _____ Do you ever have chest pain? _____ How often? How long does it last? _____ Do you have shortness of breath? _____ Have you ever been diagnosed with asthma? _____ Blood clot? _____ Do you currently have a cough? _____ Do you get recurrent respiratory infections? _____ Do you experience wheezing? _____

Neurology

Do you have a seizure disorder? _____ Do you faint? _____ If so, how often? _____ Do you have any numbness or tingling? _____ Where? _____ Do you get headaches? _____ Migraines? _____ How often? _____ Rate severity (1 – 10 with 10 being most severe pain) _____ Have you ever been paralyzed? _____ Do you have dizziness? _____ Do you have ringing in your ears? _____ Both ears? _____ How long has this been? _____ Do you have nerve pain? _____Vision changes? _____

Rheumatology/Musculoskeletal, Joint

Do you have joint pain? _____ How long? _____ Which joints? _____ Do you get leg cramps? _____ Restless legs? _____ Chronic musculoskeletal pain? _____ Have you ever been diagnosed with an autoimmune disease? _____ If so which one(s)?_____ Any arthritis? _____ What kind? _____ History of broken bones? _____ Which ones and date of injury? _____

Dermatology

Do you get recurrent rashes? _____ Acne? _____ Pigment or color changes? _____ Do you get hives? _____ Have you ever had skin cancer? _____ Any other skin complaints? _____

Female Reproduction

Are your cycles regular? _____ Period begins every _____ days. Period lasts _____ days. Your periods are: *heavy medium light* The color of the blood is *light red bright red dark red with clots.*

Do you have any spotting or bleeding between cycles? _____ Any cramps with menses? _____

Do you have premenstrual syndrome? _____ *Water retention Breast tenderness Irritability Depression Headaches Mood Swings Food Cravings Other* _____

Do you have increased hair growth on body?_____ Do you have incontinence? _____ Frequent UTIs? _____ Do you get regular Pap smears? _____ Date of last Pap smear _____ Any abnormal Paps?_____ When? _____ Any history of fibroids or ovarian cysts? _____ Any breast lumps? _____ Do you get breast imaging? _____ When was the last one and what type of image? _____

Number of pregnancies _____ Number of live births _____ Number of abortions _____

Number of miscarriages _____ Any problems getting pregnant? _____

Are you currently sexually active? _____ How often? _____ Is this more or less than last year? _____

Do you use birth control? _____ What type do you currently use? _____

Have you ever been physically, emotionally or sexually abused? _____ How old were you? _____

Any other female reproductive issues? _____

Male Reproduction

Any issues with your prostate? _____ How often do you get up at night to urinate? _____

Has this increased in recent years? _____ Do you have difficulty starting or stopping urination or flow rate? _____ Any problems with getting or maintaining an erection? _____ Any sores on your genitals? _____ Any abnormal discharge from your penis? _____

Have you ever had a hernia? _____ Any testicular masses? _____

Are you currently sexually active? _____ How often? _____ Is this more or less than last year? _____

Do you use birth control? _____ What type do you currently use? _____

Have you ever been physically, emotionally or sexually abused? _____ How old were you? _____

Any other male reproductive issues? _____

Kidneys and Bladder

How much water do you drink a day? _____ Does your urine have a strong odor? _____

How many bladder infections have you had in the last three years? _____

Have you had recurrent bladder infections? _____ How were they treated? _____

Do you ever have any burning sensation during or after urination? _____

What color is your urine? *Dark yellow bright yellow cloudy pale clear*

Occupational/Household/Exposure

How long have you lived at your present address? _____

Where have you lived previously? _____

Have you lived in homes with old construction? _____ New construction?_____ Damp or moldy conditions? _____ Mold exposure date _____ House remediated? _____ Do you have specialized air filtration at home? _____

Do you work in an office building? _____ Do the windows open? _____

Do you have specialized air filtration at your work place? _____ Do you work in the presence of toxic fumes or chemicals? _____ If so, what chemicals? _____

Do any of your hobbies involve toxic materials? _____

Any exposure to pesticides, solvents or any other chemicals or heavy metals? Please list.

_____

Are you currently or have you ever been exposed regularly to second hand smoke? _____

Do you drink *bottled filtered tap* water?

Do you currently have amalgam fillings? _____ If so, how many? _____

If they were removed, indicate when and by whom: _____

Date(s) of removal _____ Were they removed by a biological dentist? _____

Any other dental issues? _____ Root canals? _____

Misc

Any night sweats? _____ Weight change? _____

What is your body temperature compared to others? *Warmer Cooler Average*

What are the temperatures of your hands and feet generally? *Warm Cool Average*

How often do you suffer from colds, flu, sore throat or infections? _____

When you rise quickly from sitting or lying do you ever get dizzy? _____

Do you have difficulty perspiring? _____ Do you perspire when you exercise? *Lightly Moderately Heavily*. Do you perspire when not exercising? _____ If so, at what times? _____

Does your perspiration have a strong odor? _____

Is there anything else you would like to comment on?

_____

_____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally, emotionally and spiritually. The nature of your responses to the following questions will help to understand your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1) Why did you choose to come to see the doctors at Pathways to Natural Health?

2) What do you know about their approach?

3) What expectations do you have from this visit?

4) What long term expectations do you have of me personally as your doctor?

5) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)
0% 0 1 2 3 4 5 6 7 8 9 10 100%

6) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive or don't support your health? (please list)

7) What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that we will be sharing with you?

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.