

Seattle Healing Arts Center

PATIENT HEALTH HISTORY

THIS INFORMATION WILL BE CONTAINED IN YOUR MEDICAL HEALTH HISTORY

PLEASE PRINT

Name (first, middle, last)		Age:	Today's Date:
PAST HISTORY			
Please give names and dates		Major illnesses:	
Medications:			
previous hospitalizations or surgeries:			
WELL BEING			
Goals for Health:			
What practices or activities do you use to sustain your health and well being?			
Who do you turn to for support? Who are in your community?			
Who lives in your household?			
What causes stress for you?			
DIET: Fast Food All American Vegetarian Balanced Other			
SMOKING: Packs per day Number of years Years stopped Pipe Cigar Chew			
ALCOHOL: Never Occasional Moderate Heavy Alcohol Problem? Y N How much each week?			
EXERCISE: Never Occasional Moderate Often Favorite types?			
CAFFEINE: Coffee: cups per day Tea: cups per day			
Height: Weight Weight at age 20 Weight change last year: gain lbs. lost lbs.			
OCCUPATIONAL EXPOSURES: Asbestos Other (describe)			
DRUGS: Please check off drugs presently used and explain frequency of use (daily, weekly, etc.)			
<input type="checkbox"/> Sleeping pill	<input type="checkbox"/> Allergy medicine(s)	<input type="checkbox"/> Blood thinner	<input type="checkbox"/> Antibiotics
<input type="checkbox"/> Tranquilizer	<input type="checkbox"/> Nose sprays	<input type="checkbox"/> "Hard drugs"	<input type="checkbox"/> Asthma medicine
<input type="checkbox"/> Anti Depressant	<input type="checkbox"/> Cortisone/steroids	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Shots
<input type="checkbox"/> Pain pill	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Other(s) - Specify
<input type="checkbox"/> Diet pill	<input type="checkbox"/> Heart pill	<input type="checkbox"/> Laxative	
<input type="checkbox"/> Diabetes pill	<input type="checkbox"/> Digitalis	<input type="checkbox"/> Antacids	
<input type="checkbox"/> Estrogen hormone	<input type="checkbox"/> Nitroglycerin	<input type="checkbox"/> Decongestant	
<input type="checkbox"/> Birth control pill	<input type="checkbox"/> Water pill (diuretic)	<input type="checkbox"/> Vitamins	
<input type="checkbox"/> Insulin	<input type="checkbox"/> Blood pressure pill	<input type="checkbox"/> Iron	
ALLERGIES:	FAMILY HISTORY:	CHILDRENS AGES/NAMES	
Food sensitivities:	Diabetes		
	Heart disease		
Drug allergies/Type of reaction:	High blood pressure		
	Thyroid		
	Stroke		
	Cancer		
	Alcoholism		

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PLEASE STATE YOUR CHIEF CONCERNS, MAIN PROBLEM, OR REASON (S) FOR SEEING THE DOCTOR:

SYSTEM REVIEW: Check if you have any symptoms or problems to any important or significant degree.

Tired all the time	Frequent chest colds	Indigestion	Sugar in urine
Don't feel well	Bronchitis	Heartburn	Hypoglycemia
Weakness	Pneumonia	Nervous stomach	Low blood sugar
Weight problem	Shortness of breath	Ulcers	Thyroid trouble
Fluid retention	Asthma/wheezing	Vomiting blood	DATE OF last urinary or bladder infection:
Lack of exercise	Hayfever	Black or bloody stools	
DATE OF LAST PHYSICAL EXAM:	Pleurisy	Rectal bleeding	Bladder problems
	Chest pain	Abdominal pain	Kidney infection
Headache	Heart trouble	Nervous or spastic colon	Kidney trouble
Migraine	Heart murmur	Collis	Kidney stone
Fainting	Heart palpitation/tracing	Diarrhea	Difficulty with urine
Dizziness	Chest tightness/pressure	Constipation	Protein or blood in urine
Epilepsy/seizure	Angina	Change in bowel habits	Sexually transmitted disease
Ear/hearing problem	Tire easily	Hemorrhoids	Skin rash
Ringin in the ears	Enlarged heart	Gall bladder trouble	Skin trouble
Stuffy nose	Rheumatic fever	Hepatitis	Allergy
Nose bleeds	Leg pain on walking	Liver disease	Food avoidance
Sinus trouble	Varicose veins	Hernia	Bleed or bruise easily
DATE OF LAST DENTAL EXAM:	Phlebitis	Food intolerance	Anemia
	Ankle/leg swelling	Nervous	Blood disease
Persistent hoarseness	DATE OF LAST CHEST X-RAY:	Tense/irritable	Infertility problem
Glasses		Bored	Sexual difficulty
Vision/eye trouble	DATE OF LAST Electrocardiogram:	Depressed	
Glaucoma		Trouble sleeping	MEN ONLY:
Cataract	Arthritis/joint pain	Relationship problems	Discharge from penis
DATE OF LAST EYE EXAM:	Gout	Job problems	Prostate trouble
	Neck pain	Personal problems	Stream weak or slow
Frequent cough	Back pain or trouble	Nervous breakdown	Swelling or pain in testes
Cough phlegm	Bursitis/tendentious	Psychiatrist seen	DATE OF VASECTOMY:
Cough blood	Swallowing trouble	High blood sugar	

WOMEN ONLY:

Age menstruation began: _____ Periods: ___Regular ___Irregular ___Painful ___Heavy Every _____ days

Comments: _____ Last menstrual period date(s): _____

Number of PREGNANCIES: _____ Number of BIRTHS: _____ Number of Miscarriages/Abortions: _____

Dates of PREGNANCIES / outcome: _____

Type of birth control: _____ How Long? _____ IUD? ___Yes ___No Years inserted _____

Date of last mammogram _____ History of breast disease? _____

Symptoms of menopause? _____

(Additions to health history)
