Naturally Healthy Family Medicine
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Comprehensive Health Profile

Name ____ Date ______________________

Instructions: Put a check in the boxes applicable to you or dependent (whoever is the patient). When necessary, write in your answer.

1) ILLNESSES/INJURIES you have had:

- ☐ Colitis
- ☐ Bladder or Kidney Infections
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Mononucleosis
- ☐ Tuberculosis (TB)
- ☐ Veneral disease (VD)
- ☐ Frequent colds or infections
- ☐ Serious injuries
- ☐ Head injury or concussion
- ☐ Poisoning
- ☐ Skin disorders
- ☐ Recurring headaches
- ☐ Glaucoma
- ☐ Asthma
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Peptic ulcer
- ☐ Liver/gallbladder disease
- ☐ Hemorrhoids
- ☐ Kidney problems
- ☐ Arthritis
- ☐ Recurring back or neck pain
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Diabetes
- ☐ Thyroid problems

List any other illnesses or injuries:

- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________

2) SURGERY/HOSPITALIZATIONS:

Have you had removed: When?

- ☐ Tonsils ______________
- ☐ Appendix ______________
- ☐ Gallbladder ______________
- ☐ Uterus (hysterectomy) ______________
- ☐ One or both ovaries ______________

List any other operations or periods of hospitalization for any illness

- ☐ ____________________________________
- ☐ ____________________________________
- ☐ ____________________________________
- ☐ ____________________________________

3) IMMUNIZATIONS:

Have you had any of the following immunizations:

- ☐ Polio
- ☐ Diphtheria/pertussis/tetanus (DPT)
- ☐ Measles
- ☐ Mumps
- ☐ Smallpox
- ☐ Tetanus booster (last ten years)

List any other immunizations:

- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________

Please continue on the other side

4) ALLERGIES:

- ☐ Foods
- ☐ Drugs or medication
- ☐ Other substances

List: ___________________
____
____

5) MEDICATIONS:

Do you regularly take:

- ☐ Digestive enzymes
- ☐ Laxatives
- ☐ Antacids
- ☐ Estrogen
- ☐ Sedatives
- ☐ Diet pills
- ☐ Cortisone
- ☐ Sleeping pills
- ☐ Thyroid
- ☐ Aspirin and cold medicines

6) HABITS/ENVIRONMENT:

Do you:

- ☐ Wake feeling unrested
- ☐ Have trouble sleeping
- ☐ Have problems with constipation
- ☐ Exercise: (how much—how often?)

____

- ☐ Have problems at home or work
- ☐ Have trouble relaxing or enjoying your spare time

Do you:

- ☐ Drink alcohol __________
  How much _____________
  How often _____________
- ☐ Drink coffee (cups per day) __________
- ☐ Smoke tobacco (packs per day) ______

Have you been treated for:

- ☐ Alcoholism
- ☐ Drug abuse

7) DIET

Do you:

- ☐ Feel your diet is healthy?
- ☐ Eat between meals?
- ☐ Follow a special or restricted diet?
- ☐ Avoid certain foods? Specify _________
- ☐ Drink diet sodas or consume aspartame?
- ☐ Regularly salt your food?
- ☐ Regularly eat fried foods?
- ☐ Use sugar on your food or in drinks?
- ☐ Use sugar in cooking?

List any vitamins, minerals or other dietary supplements you are taking:

8) FAMILY HISTORY

Which member of your family or near relatives have had:

- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Heart problems
- ☐ Kidney problems
- ☐ Cancer
- ☐ High blood pressure
- ☐ Stroke
- ☐ Epilepsy
- ☐ Psychiatric problems
- ☐ Asthma
- ☐ Hives or hay fever
- ☐ Arthritis or gout
- ☐ Thyroid problems
- ☐ Bleeding problems
- ☐ Weight problems

9) WOMEN ONLY: MENSTRUAL HISTORY / PREGNANCIES

Do you have:

- ☐ Irregular periods
- ☐ Cramps or pain with period
- ☐ Tension or depression before period
- ☐ Hot flashes
- ☐ High or low sex drive
- ☐ Pain during intercourse
- ☐ Any unusual bleeding or discharge

Are you:

- ☐ Pregnant or possibly pregnant
- ☐ Having trouble getting pregnant
- ☐ Using any method of birth control

Age at onset of menses: ________
Age at menopause: ________
Usual length of cycle (day 1 to next cycle) ____
Usual duration of flow: _____ days
Is your flow: light medium heavy
Date last period began: ___________

Date of last PAP smear: _________
Number of:
__________ children born alive
__________ caesarian section
__________ premature births
__________ stillborn
__________ miscarriages
__________ abortions