LAKE HOMEOPATHIC CARE

HEALTH INVENTORY

[THIS INFORMATION IS CONFIDENTIAL AND WILL ONLY BE RELEASED WITH YOUR SIGNED CONSENT]

Name _____ Today's date _____

Address _____ Birthdate _____
COUNTY

_____ Age ____ Sex ____ Height ____ Weight ____
CITY STATE ZIP

Phone: WORK: _____ HOME: _____ Legal status: S M D Sep W

Emergency contact: Name: _____ Living situation _____

Phone #: _____ Relationship _____ Education (yrs. completed):
Elem ____ HS ____ Coll ____ Voc ____ Prof ____

If under 18, parents' name/address _____ Occupation _____

Referred by _____ Retired: ☐ Yes ☐ No

Address _____ Social Security # _____

Family Physician _____

Address _____

FAMILY HISTORY

☐ *Check if family history is unknown.*

	Age	If deceased, cause of death
Father		
Mother		
Siblings		

Children	Age	Problems

Check items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles).

YES		RELATIONSHIP
☐	Alcohol/drug problem	_____
☐	Allergy/asthma	_____
☐	Anemia	_____
☐	Arteriosclerosis	_____
☐	Arthritis	_____
☐	Binge eating/bulimia	_____
☐	Bleeding problem	_____
☐	Cancer	_____
☐	Diabetes	_____
☐	Epilepsy/seizure	_____
☐	Heart disease	_____
☐	Skin disease	_____
☐	E-docrine/hormonal imbalance	_____

YES		RELATIONSHIP
☐	High blood pressure	_____
☐	High cholesterol/fat	_____
☐	Kidney disease	_____
☐	Liver disease	_____
☐	Mental illness	_____
☐	Obesity	_____
☐	Stroke	_____
☐	Suicide	_____
☐	Thyroid disease	_____
☐	Tuberculosis	_____
☐	Gastro intestinal disease	_____
☐	Syphilis	_____
☐	Gonorrhea	_____

Please turn page.

PAST HISTORY OF ILLNESS AND MEDICAL PROBLEMS

Surgery: List all surgery and approximate dates

Other hospitalizations and dates

Broken bones and/or traumatic injuries
(include all car accidents or concussions)

Current health problems
Example: High blood pressure - 10 yrs.

PAST HISTORY

YES		WHEN
☐	Acne	
☐	AIDS	
☐	Alcohol/drug problem	
☐	Allergies	
☐	Amalgams/silver fillings	
☐	Anemia	
☐	Antibiotics more than once a year	
☐	Anorexia	
☐	Anxiety	
☐	Arteriosclerosis	
☐	Arthritis	
☐	Asthma	
☐	Back pain/strain	
☐	Binge eating	
☐	Bladder infection	
☐	Blood clots	
☐	Breast lump	
☐	Bronchitis	
☐	Bulimia (self-induced vomiting)	
☐	Cancer	
☐	Cataract	
☐	Chemical sensitivity	
☐	Chicken pox	
☐	Chronic fatigue	
☐	Colds, frequent	
☐	Colitis	
☐	Congenital defect	
☐	Counseling	
☐	Depression	
☐	Diabetes	
☐	Ear infection	
☐	Eczema	
☐	Endometriosis	
☐	Epilepsy	

YES		WHEN
☐	Epstein Barr/ infectious mono	
☐	Fibrocystic breasts	
☐	Fibroids	
☐	Gallbladder problem	
☐	Glaucoma	
☐	Gonorrhea	
☐	Gout	
☐	Hay fever	
☐	Hearing problem	
☐	Heart attack	
☐	Heart failure	
☐	Heart problem	
☐	Hemorrhoids	
☐	Hepatitis	
☐	Herpes	
☐	Hiatal Hernia	
☐	High blood pressure	
☐	High cholesterol/ triglycerides	
☐	Hives	
☐	Hypoglycemia	
☐	Insomnia	
☐	Kidney infection	
☐	Kidney stones	
☐	Kidney problem	
☐	Liver disease	
☐	Menstrual problem	
☐	Mental illness	
☐	Migraine	
☐	Nervous condition	
☐	Neurologic problem	
☐	Overweight (20 lbs)	
☐	Panic Attacks	
☐	Pelvic infection	
☐	Peptic ulcer	

YES		WHEN
☐	Periodontal disease	
☐	Phlebitis	
☐	Pneumonia	
☐	Premenstrual tension	
☐	Prostate problem	
☐	Psychotherapy	
☐	Reactions to vaccinations	
☐	Rheumatic fever	
☐	Root canal	
☐	Scarlet fever	
☐	Sexually transmitted disease	
☐	Sinusitis	
☐	Skin problem	
☐	Sleep disorder	
☐	Stroke	
☐	Suicide attempt	
☐	Syphilis	
☐	Taken steroid (cortisone/prednisone)	
☐	Thyroid problem	
☐	Tonsillitis	
☐	Tooth problems	
☐	Tuberculosis	
☐	Urine problem	
☐	Vaginitis	
☐	Vision problem	
☐	Warts	
☐	Other problems	

REVIEW OF SYSTEMS

Answer "yes" if you have had these symptoms ***in the last 6 months.***

YES

- ☐ Chronic fatigue
- ☐ Mood swings
- ☐ Chronic depression
- ☐ Trembling episodes
- ☐ Light-headedness
- ☐ Food craving
- ☐ Frequent infection
- ☐ Night sweats
- ☐ Swollen glands
- ☐ Skin rash
- ☐ Chills/fever
- ☐ Change in skin/nails
- ☐ Change in wart or mole
- ☐ Abnormal bleeding/bruising
- ☐ Change in hair loss/growth
- ☐ Irritability
- ☐ Restlessness
- ☐ Headaches
- ☐ Dizziness
- ☐ Balance problem
- ☐ Head injury
- ☐ Seizure/convulsion
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Fainting
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of any vision
- ☐ Halos around lights
- ☐ Excessive tearing/itching
- ☐ Eye pain
- ☐ Dark circles under eyes
- ☐ Date last eye exam _____
- ☐ Loss of hearing
- ☐ Ringing/buzzing in ears
- ☐ Sinus trouble
- ☐ Nosebleed
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Change in voice
- ☐ Dental problem
- ☐ Dry mouth
- ☐ Excessive salivation
- ☐ Bleeding gums
- ☐ Mouth breather

YES

- ☐ Chronic cough
- ☐ Bloody/yellow sputum
- ☐ Shortness of breath
- ☐ with exertion
- ☐ at night
- ☐ Bronchitis
- ☐ Chest pain with breathing
- ☐ High blood pressure
- ☐ Chest pain or pressure
- ☐ at rest
- ☐ with exertion
- ☐ with stress
- ☐ with eating
- ☐ down left arm, neck or back
- ☐ accompanied by nausea, sweating, anxiety
- ☐ Irregular heartbeat
- ☐ Skip beats
- ☐ Palpitations
- ☐ Fast heart beat
- ☐ Heart murmur
- ☐ Swelling feet/legs
- ☐ Cold hands/feet
- ☐ Leg cramps at night
- ☐ Joint pain
- ☐ Pain or fatigue in legs with exercise
- ☐ Burning feet
- ☐ Sore legs/feet
- ☐ Color change legs/arms
- ☐ Difficulty swallowing
- ☐ Pain/discomfort when eating
- ☐ Bad teeth
- ☐ Belching
- ☐ Coating on tongue
- ☐ Canker sores
- ☐ Pain relieved by eating
- ☐ Nausea/vomiting
- ☐ Trouble with fried foods
- ☐ Bloating of abdomen
- ☐ Bowel gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Clay-colored stool
- ☐ Mucus in stool
- ☐ Hemorrhoids
- ☐ Rectal bleeding

YES

- ☐ Abdominal pain
- ☐ Change in diet
- ☐ Pain/burning urination
- ☐ Frequent urination
- ☐ Urination at night
- ☐ Blood in urine
- ☐ Foul odor to urine
- ☐ Low back pain
- ☐ Loss of control of urine

MEN

- ☐ Enlarged prostate
- ☐ Decreased urine stream
- ☐ Unable to interrupt stream
- ☐ Dribbling after urination
- ☐ Pus or drainage from penis
- ☐ Genital swelling/rash
- ☐ Problem with sexual function

WOMEN

Last menstruation period _____

Age began menstruation _____

Age began menstruation _____

Age at menopause _____

Number of pregnancies _____

Number of live births _____

Number of abortions/miscarriages _____

- ☐ Complication of pregnancy
- ☐ Used birth control pills
- ☐ Used IUD type: _____

Usual length of cycle _____

Usual length of period _____

- ☐ Change in cycle
- ☐ Spotting between periods
- ☐ Discomfort with periods
- ☐ Premenstrual tension
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Itching
- ☐ Self breast examination
- ☐ Problem w/sexual function
- ☐ Lump in breast
- ☐ Abnormal pap smear
- ☐ Infertility

Date of last pap smear _____

Please turn page.

PERSONAL HISTORY

Current medications

List all prescriptions and non-prescriptions

_____

_____

_____

_____

_____

_____

Vitamin and mineral supplements

Type and dosage

_____

_____

_____

_____

_____

_____

Allergies

I am allergic to the following medications:

_____

_____

_____

_____

_____

_____

_____

Food allergies and method of testing

_____

_____

_____

_____

_____

_____

_____

Lifestyle

List your favorite foods or cravings

_____

_____

_____

_____

I am now or have been a smoker. ☐ yes ☐ no

How many years have you smoked? _____

How much? _____

When did you quit? _____

I estimate my use of:

coffee: _____ cups/day decaf: _____ cups/day

I use ☐ beer ☐ wine ☐ "hard" liquor.

I consider myself a ☐ non-drinker ☐ social drinker
☐ heavy drinker ☐ alcoholic ☐ recovering alcoholic

I use ☐ marijuana ☐ other drugs _____

I have participated in an exercise program. ☐ yes ☐ no

I exercise on a regular basis. ☐ yes ☐ no
_____ Times _____ Week/Month

I think this is enough exercise. ☐ yes ☐ no

I would like to do more exercise. ☐ yes ☐ no

I find my work ☐ too demanding ☐ boring ☐ satisfactory
☐ very satisfying.

My sex life is satisfactory. ☐ yes ☐ no

I do the following for relaxation/recreation: _____

_____

_____

I sleep well. ☐ yes ☐ no

I worry about ☐ money ☐ job ☐ family life
☐ relationships ☐ other _____

I currently see a psychotherapist or other mental health professional. ☐ yes ☐ no

I have had a therapeutic massage. ☐ yes ☐ no

I currently see a chiropractor, osteopath, or other physical therapy person. ☐ yes ☐ no

I have been arrested. ☐ yes ☐ no

I have been in the military service. ☐ yes ☐ no

I have been a victim of ☐ physical ☐ sexual
☐ emotional abuse.

My spiritual life is satisfactory. ☐ yes ☐ no

I am currently involved in a regular spiritual program
☐ yes ☐ no

My last physical exam was _____