

HEALTH HISTORY (Confidential)

Name _____ Today's Date _____
 Age _____ Birth date _____ Date of last physical exam _____

What is your reason for visit? _____

SYMPTOMS: Check symptoms you currently have or have had in the past year

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight

- Nervousness
- Numbness

- Sweats

MUSCLE/JOINT/BONE

Pain, Weakness, Numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids

- Indigestion
- Nausea

- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR

- Chest Pain
- High Blood Pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness

- Loss of hearing
- Nosebleeds

- Persistent cough
- Ringing in ears
- Sinus problems
- Vision- Flashes
- Vision- Halos

SKIN

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sores that won't heal

MEN ONLY

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other _____

WOMEN ONLY

- Abnormal pap smear
- Bleeding between period
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple Discharge
- Painful intercourse
- Vaginal discharge
- Other _____

Date of last menstrual cycle _____

Date of last Pap smear _____

Have you had a Mammogram? _____

Are you pregnant? _____
of children? _____

CONDITIONS: Check conditions you currently have or have had in the past

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding disorders
- Breast lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts

- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes

- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio

- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Thyroid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

MEDICATIONS - List medications you are currently taking

ALLERGIES to medications or substances

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____

PART I

Please list the 5 major health concern in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II Please circle the appropriate number "0 - 3" on all questions below.
0 as the least/never to 3 as the most/always.

Category I				Category V					
Feeling that bowels do not empty completely	0	1	2	3	Greasy or high fat foods cause distress	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3	Lower bowel gas and or bloating several hours after eating	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3	Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Diarrhea	0	1	2	3	Unexplained itchy skin	0	1	2	3
Constipation	0	1	2	3	Yellowish cast to eyes	0	1	2	3
Hard dry or small stool	0	1	2	3	Stool color alternates for clay colored to normal brown	0	1	2	3
Coated tongue of "fuzzy" debris on tongue	0	1	2	3	Reddened skin, especially palms	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3	Dry or flaky skin and/or hair	0	1	2	3
More than 3 bowel movements daily	0	1	2	3	History of gallbladder attacks or stones	0	1	2	3
Do you use laxatives frequently	0	1	2	3	Have you had your gallbladder removed	Yes	No		
Category II				Category VI					
Excessive belching burping or bloating	0	1	2	3	Crave sweets during the day	0	1	2	3
Gas immediately following a meal	0	1	2	3	Irritable if meals are missed	0	1	2	3
Offensive breath	0	1	2	3	Depend on coffee to keep yourself going or started	0	1	2	3
Difficult bowel movements	0	1	2	3	Get lightheaded and if meals are missed	0	1	2	3
Sense of fullness during and after meals	0	1	2	3	Eating relieves fatigue	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3	Feel shaky, jittery, tremors	0	1	2	3
Category III				Category VII					
Stomach pain, burning or aching 1- 4 hours after eating	0	1	2	3	Fatigue after meals	0	1	2	3
Do you frequently use antacids	0	1	2	3	Crave sweets during the day	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3	Eating sweets does not relieve cravings for sugar	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3	Must have sweets after meals	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3	Waist girth is equal or larger than hip girth	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3	Frequent urination	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0	1	2	3	Increased thirst & appetite	0	1	2	3
Category IV				Category VIII					
Roughage and fiber cause constipation	0	1	2	3	Cannot stay asleep	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3	Crave salt	0	1	2	3
Pain, tenderness, soreness on left side under rib cage bloated	0	1	2	3	Slow starter in the morning	0	1	2	3
Excessive passage of gas	0	1	2	3	Afternoon fatigue	0	1	2	3
Nausea and/or vomiting	0	1	2	3	Dizziness when standing up quickly	0	1	2	3
Excessive passage of gas	0	1	2	3	Afternoon Headaches	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	0	1	2	3	Headaches with exertion or stress	0	1	2	3
Frequent urination	0	1	2	3	Weak nails	0	1	2	3
Increased thirst and appetite	0	1	2	3					
Difficulty losing weight	0	1	2	3					

Category IX				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X				
Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervousness and emotional	0	1	2	3
Insomnia	0	1	2	3
Night Sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII				
Diminished sex drive	0	1	2	3
Menstrual disorders of lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Male Only)				
Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males Only)				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating Females Only)				
Are you a menopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial Hair Growth	0	1	2	3
Hair Loss/Thinning	0	1	2	3

Category XVII (Menopausal Females only)				
How many years have you been menopausal?				
Do you ever have uterine bleeding since menopause?	Yes	No		
Hot Flashes	0	1	2	3
Mental Fogginess	0	1	2	3
Disinterest in Sex	0	1	2	3
Mood Swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breast	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal, pain, dryness or itching	0	1	2	3

PART III

How many alcohol beverages they consume per week? _____

How many times do you eat out per week? _____

How many times a week do you eat fish? _____

How many caffeinated beverages do you consume per day? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you schedule for work outs? _____

List the three worst foods you eat during the average week? _____, _____, _____

List the three healthiest foods you eat during the average week? _____, _____, _____

Rate your stress levels on a scale of 1-10 during the average week. _____

Circle any of the following medication that you are currently taking?

- | | | | |
|-----------------|--------------------|-----------------------|----------------------|
| Antacids | Antihistamines | Diuretics | Hydrocortisone Cream |
| Antibiotics | Anti-Inflammatory | High Blood Pressure | Oral Contraceptives |
| Antidepressants | Anxiety Medication | High Cholesterol | Thyroid Hormones |
| Antifungals | Aspirin/Tylenol | Hormones Replacements | Others: |