marinhealth

# HEALTH HISTORY

LAST NAME, FIRST: _____ DATE _____

**Please list 5 major health concerns in order of importance to you:**

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

| Family History | Self | Father | Mother | Sibling(s) | Children |
|---|---|---|---|---|---|
| Arthritis | | | | | |
| Asthma | | | | | |
| Cancer | | | | | |
| Allergies | | | | | |
| Heart Trouble | | | | | |
| High Blood Pressure | | | | | |
| Stroke | | | | | |
| Diabetes | | | | | |

**If your complaint is pain related, please answer the questions below:**

Rate the following on a scale of 0 to 10 (0 being none and 10 being the maximum possible):

Pain intensity right now _____

Usual pain intensity experienced over the past week _____

Amount that the pain interfered with daily activities _____

**Frequency of Pain**

- ☐ Continuous
- ☐ Several Times / Day
- ☐ Once / Day
- ☐ Three Times / Day
- ☐ Once / Week

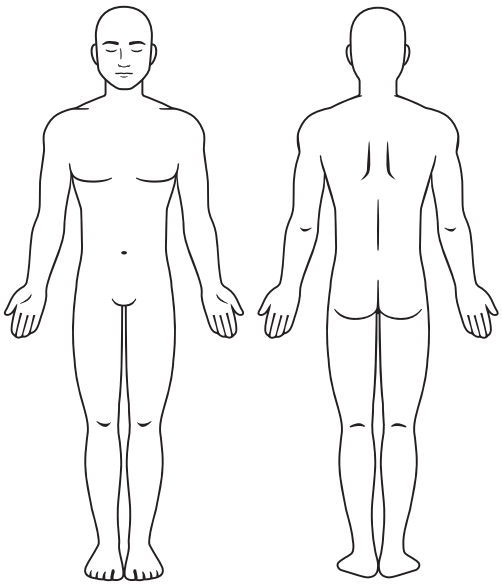
**Duration of Pain**

- ☐ Seconds
- ☐ Minutes
- ☐ Hours
- ☐ Days
- ☐ Continuous

**Description of Pain (Check all that apply)**

- ☐ Throbbing
- ☐ Gnawing
- ☐ Tender
- ☐ Cramping
- ☐ Hot
- ☐ Cold
- ☐ Dull
- ☐ Burning
- ☐ Heavy
- ☐ Aching
- ☐ Stabbing

**Please Mark Your Areas of Pain**



LAST NAME, FIRST: _____

## Surgical / Hospitalization

| Description | Date | Comments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Medications & Supplements

Please list all prescription medications and supplements you use. Include those that you only use occasionally. Remember inhalers, eye drops, nose sprays, topical creams, and vitamins.

## Medications

| Prescription Name | Purpose | How Long | Dose | How Often |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Supplements

| Supplement Name | Purpose | How Long | Dose | How Often |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

LAST NAME, FIRST: _____

| Current/ Recent | Past | LIVER/GALLBLADDER |
|---|---|---|
| ☐ | ☐ | Depression/Stress |
| ☐ | ☐ | Headaches/Migraines |
| ☐ | ☐ | Red/Dry/Itchy Eyes |
| ☐ | ☐ | Visual Problems/Blurred Vision |
| ☐ | ☐ | Dizziness |
| ☐ | ☐ | Gall Stones Feeling of Lump in Throat |
| ☐ | ☐ | Clenching of Teeth at Night |
| ☐ | ☐ | Muscle Cramping/Twitching |
| ☐ | ☐ | Neck/Shoulder Pain/Tightness |
| ☐ | ☐ | Joint Pain |
| ☐ | ☐ | Poor Circulation |
| ☐ | ☐ | Soft/Brittle Nails |
| ☐ | ☐ | Bad Taste |
| ☐ | ☐ | Bad Breath |
| ☐ | ☐ | Do you crave: Sour |
| ☐ | ☐ | Irritability/Anger |

| | | KIDNEY/URINARY BLADDER |
|---|---|---|
| ☐ | ☐ | Urinary Problems |
| ☐ | ☐ | Bladder Infection |
| ☐ | ☐ | Dropped Bladder |
| ☐ | ☐ | Incontinence |
| ☐ | ☐ | Lack of Bladder Control |
| ☐ | ☐ | Weakness/Pain in Low Back |
| ☐ | ☐ | Decreased Bone Density Feel |
| ☐ | ☐ | Cold Easily |
| ☐ | ☐ | Cold Hands/Feet |
| ☐ | ☐ | Low Sex Drive/Libido |
| ☐ | ☐ | Excess Sex Drive/Libido |
| ☐ | ☐ | Poor Memory |
| ☐ | ☐ | Loss of Hair/Grey Hair |
| ☐ | ☐ | Hearing Problems |
| ☐ | ☐ | Cavities |
| ☐ | ☐ | Hot Flashes/Night Sweats |
| ☐ | ☐ | Do you crave: Salt |
| ☐ | ☐ | Fear |

| | | HEART/SMALL INTESTINES |
|---|---|---|
| ☐ | ☐ | Heart Palpitations |
| ☐ | ☐ | Chest Pain |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Low Blood Pressure |
| ☐ | ☐ | Insomnia/Sleep Problems |
| ☐ | ☐ | Vivid Dreams |
| ☐ | ☐ | Easily Startled |
| ☐ | ☐ | Do you crave: Bitter |
| ☐ | ☐ | Restlessness/Agitation |

| Current/ Recent | Past | LUNG/LARGE INTESTINES |
|---|---|---|
| ☐ | ☐ | Bloody Cough |
| ☐ | ☐ | Dry Cough |
| ☐ | ☐ | Cough with Sputum |
| ☐ | ☐ | Nasal Discharge — Color: |
| ☐ | ☐ | White Yellow Green |
| ☐ | ☐ | Post Nasal Drip |
| ☐ | ☐ | Sinus Infection/Congestion |
| ☐ | ☐ | Itchy, Red or Painful Throat |
| ☐ | ☐ | Dry Mouth/Throat /Nose |
| ☐ | ☐ | Skin Rashes/Hives |
| ☐ | ☐ | Snoring |
| ☐ | ☐ | Shortness of Breath |
| ☐ | ☐ | Allergies/Asthma |
| ☐ | ☐ | Low Resistance to Illness |
| ☐ | ☐ | Sneezing |
| ☐ | ☐ | Mild Fever Comes & Goes |
| ☐ | ☐ | Smoke Cigarettes |
| ☐ | ☐ | Emphysema |
| ☐ | ☐ | Bronchitis |
| ☐ | ☐ | Black or Bloody Stools |
| ☐ | ☐ | Constipation |
| ☐ | ☐ | IBS |
| ☐ | ☐ | Diarrhea |
| ☐ | ☐ | Colitis/Spastic Colon |
| ☐ | ☐ | Do you crave: Pungent |
| ☐ | ☐ | Grief/Sadness |

| | | SPLEEN/STOMACH |
|---|---|---|
| ☐ | ☐ | Body Heaviness |
| ☐ | ☐ | Hard to get up in the Morning |
| ☐ | ☐ | Muscles Often Feel Tired |
| | | Energy Level : 1–10 (low to high) |
| | | _____ |
| ☐ | ☐ | Edema ☐ Hands ☐ Feet |
| ☐ | ☐ | Easily Bruising /Bleeding |
| ☐ | ☐ | Bad Breath |
| ☐ | ☐ | Nausea/Vomiting |
| ☐ | ☐ | Gas/Belching |
| ☐ | ☐ | Hemorrhoids |
| ☐ | ☐ | Diarrhea |
| ☐ | ☐ | Constipation |
| ☐ | ☐ | Abdominal Pain |
| ☐ | ☐ | Indigestion/Heartburn |
| ☐ | ☐ | Brain Foggy |
| ☐ | ☐ | Tendency to Gain Weight |
| ☐ | ☐ | Do you crave: Sweet |
| ☐ | ☐ | Over-thinking/Worry |