LIFELINE Internal Medicine

HEALTH HISTORY

Name _____ **Date** _____

Address _____

City, Zip _____ **(H) Phone** _____

Email _____ **(W or C) Phone** _____

Employer _____ D.O.B.____/_____/_____ Sex _____ Number of Children _____

Marital Status ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit:

1_____ Date condition began _____

2_____ Date condition began _____

3_____ Date condition began _____

List any health problems for which you are currently being treated:

_____

_____

_____

What types of therapies have you tried for these problems or to improve your health overall:

❑ diet ❑ fasting ❑ vitamin/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

Do you experience any of these general symptoms EVERY DAY?

❑ Panic attacks	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/Inflammation	❑ Bleeding
❑ Depression	❑ Debilitating fatigue	❑ Nausea	❑ Fecal incontinence	❑ Poor wound healing	❑ Discharge
❑ Dizziness	❑ Disinterest in sex	❑ Vomiting	❑ Urinary incontinence	❑ Low grade fever	❑ Itching/rash
❑ Headaches	❑ Disinterest in eating	❑ Diarrhea	❑ Ringing in ears	❑ Intolerant of cold	

Primary Care Physician Name:_____

Primary Care Physician Phone Number:_____

Laboratory procedures performed (blood, stool, urine, etc.) _____

Outcome _____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): **1 2 3 4 5 6 7 8 9 10**

Identify the major cause of stress (eg. work, finances, relationship(s), etc.) _____

What is your overall energy level on a scale of 1 to 10 (1 being the lowest, 10 the highest): **1 2 3 4 5 6 7 8 9 10**

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right

Your weight today _____lbs Your weight at age 20 _____lbs Your ideal weight _____lbs

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Are you exposed to potentially harmful chemicals (eg. pesticides, solvents, etc.) _____

_____

LIFELINE Internal Medicine

Please continue on back ⇨

HEALTH HISTORY CONTINUED

Current medications (prescriptions or over-the-counter):

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any known allergies:

_____ _____ _____

List any known drug allergies:

_____ _____ _____

How committed are you to making a change in your health (1 = least, 10 = most committed): **1 2 3 4 5 6 7 8 9 10**

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Chest pain
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy/seizures
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ IBD/colitis
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis, etc)
- ❑ Stroke
- ❑ Thyroid problems
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroid/ovarian cysts
- ❑ PMS (premenstrual syndrome)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Menopause
- ❑ Surgical menopause
- ❑ C-section. How many_____

Date of last GYN exam _____

PAP ❑ + ❑ -

Mammogram ❑ + ❑ -

Number of pregnancies _____

Number of children _____

Age of first period _____

Date of last period _____

Length of cycle _____days

Any recent changes in menstrual flow (eg. heavier, more clots, etc)

_____

Medical (Men)

- ❑ Benign prostatic hyperplasia
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma/lung disease
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Hypertension
- ❑ Infertility
- ❑ Mental illness
- ❑ Migraine headaches
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke

Other _____

Health Habits

- ❑ Smoke
- ❑ Use alcohol
- ❑ Caffeine (coffee, pop, etc.)

Glasses of water/day _____

Hours of sleep/night _____

Number of stools/day _____

Consistency of stools:

❑hard ❑soft ❑marbles

❑normal ❑other_____

Exercise

- ❑ none
- ❑ 1 to 2 days per week
- ❑ 3 to 4 days per week
- ❑ 5 to 7 days per week
- ❑ Less than 45 minutes per workout
- ❑ More than 45 minutes per workout

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan

Eating habits

- ❑ One meal per day
- ❑ Two meals per day
- ❑ Three meals per day
- ❑ Graze (small frequent meals)
- ❑ Eat constantly whether hungry or not
- ❑ Skip meals – which ones _____

_____

I Would Like To:

- ❑ Feel more vital
- ❑ Feel less pain
- ❑ Lose weight
- ❑ Improve memory
- ❑ Be less indecisive
- ❑ Increase sex drive
- ❑ Use less medications
- ❑ Have more endurance
- ❑ Sleep better
- ❑ Be stronger
- ❑ Be less moody
- ❑ Feel more motivated
- ❑ Increase muscle tone
- ❑ Slow down accelerated aging

LIFELINE Internal Medicine

Male Hormone Questionnaire

Circle the number that best applies for each line: **0** = never, **1** = sometimes, **2** = often, **3** = constantly

"The best gift we can give in any interaction is to leave people feeling lighter, happier, and more at peace."
– David Simon

Confusion or memory loss in stressful situations	0	1	2	3	Heart palpitations or high blood pressure	0	1	2	3
Angry, anxious or quarrelsome	0	1	2	3	Weight gain in the trunk (waist and abdomen)	0	1	2	3
Respiratory infections or allergies	0	1	2	3	Thinning skin or easy bruising	0	1	2	3
Crave salty foods or lack of thirst	0	1	2	3	Increased facial or body hair	0	1	2	3
Get dizzy or light-headed on standing	0	1	2	3	Difficulty getting to sleep or staying asleep	0	1	2	3
Bouts of colitis, diarrhea or bloating	0	1	2	3	GERD (gastric reflux) or ulcers	0	1	2	3
Low stamina and intolerant of exercise	0	1	2	3	Ongoing tension or constant dull headache	0	1	2	3
Aches and pains	0	1	2	3	Sugar cravings	0	1	2	3
Skin rashes, eczema or psoriasis	0	1	2	3	Loss of muscle mass	0	1	2	3
Unable to handle stressful situations	0	1	2	3	Irritability and depression	0	1	2	3
AD TOTAL _____					AE TOTAL _____				

Hard to lose weight or swollen all over	0	1	2	3	Face looking aged and has more wrinkles	0	1	2	3
Very low energy or fatigue and exhaustion	0	1	2	3	Loss of sex drive and low ejaculatory volume	0	1	2	3
Dry and rough skin on face, arms, legs	0	1	2	3	Ongoing fatigue that worsens with activity	0	1	2	3
Dry, coarse hair and hair loss	0	1	2	3	Loss of strength and less muscle mass	0	1	2	3
Low body temperature or always feeling cold	0	1	2	3	Hot flushes or unusual sweating spells	0	1	2	3
Constipation or infrequent stools (< 1/day)	0	1	2	3	Loss of height with age	0	1	2	3
Puffiness on face or under the eyes (bags)	0	1	2	3	Body hair becoming more diffuse	0	1	2	3
Apathetic or lack of interest in anything	0	1	2	3	Loss of interest in life	0	1	2	3
Slow reaction and poor concentration	0	1	2	3	Depression the whole day long	0	1	2	3
Brittle or slow growing nails	0	1	2	3	Indecisive and less self-confidence	0	1	2	3
thD TOTAL _____					TD TOTAL _____				

Feeling tense or nervous without cause	0	1	2	3	Low self-esteem	0	1	2	3
Anxious with a lack of inner peace	0	1	2	3	Tendency to social isolation	0	1	2	3
Light, restless sleep	0	1	2	3	Overall poor health	0	1	2	3
Reduced urine flow	0	1	2	3	Exhaustion with poor recovery after activity	0	1	2	3
Need more time to urinate or prostate problems	0	1	2	3	Sore feet after long walks	0	1	2	3
Constipation	0	1	2	3	Feeling of rapid aging	0	1	2	3
Developing breasts	0	1	2	3	Excessive need for sleep – 9 or more hours	0	1	2	3
Chronically tense muscles	0	1	2	3	Outbursts of panic and anxiety	0	1	2	3
Male pattern baldness	0	1	2	3	Tendency to be depressed	0	1	2	3
Excess body hair	0	1	2	3	Abdomen becoming flabby	0	1	2	3
PD TOTAL _____					GD TOTAL _____				

LIFELINE Internal Medicine

Female Hormone Questionnaire

Circle the number that best applies for each line: **0** = never, **1** = rarely, **2** = sometimes, **3** = almost always

"The best gift we can give in any interaction is to leave people feeling lighter, happier, and more at peace."
– David Simon

Confusion or memory loss in stressful situations	0	1	2	3	Heart palpitations or high blood pressure	0	1	2	3
Angry, anxious or quarrelsome	0	1	2	3	Weight gain in the trunk (waist and abdomen)	0	1	2	3
Respiratory infections or allergies	0	1	2	3	Thinning skin or easy bruising	0	1	2	3
Crave salty foods or lack of thirst	0	1	2	3	Increased facial or body hair	0	1	2	3
Get dizzy or light-headed on standing	0	1	2	3	Difficulty getting to sleep or staying asleep	0	1	2	3
Bouts of colitis, diarrhea or bloating	0	1	2	3	GERD (gastric reflux) or ulcers	0	1	2	3
Low stamina and intolerant of exercise	0	1	2	3	Ongoing tension or constant dull headache	0	1	2	3
Aches and pains	0	1	2	3	Sugar cravings	0	1	2	3
Skin rashes, eczema or psoriasis	0	1	2	3	Loss of muscle mass	0	1	2	3
Unable to handle stressful situations	0	1	2	3	Irritability and depression	0	1	2	3
AD TOTAL					AE TOTAL				

Decreased mental ability or memory loss	0	1	2	3	Breasts feel larger, swollen or more tender	0	1	2	3
Emotionally sensitive or crying easily	0	1	2	3	Foggy thinking	0	1	2	3
Hot flashes and night sweats	0	1	2	3	Anxiety with depression or irritability	0	1	2	3
Vaginal dryness and/or painful intercourse	0	1	2	3	Heavy bleeding during cycle	0	1	2	3
Inability to hold urine without leakage	0	1	2	3	Water retention with bloating	0	1	2	3
Breasts beginning to lose tone	0	1	2	3	Rapid weight gain in abdomen, hips & thighs	0	1	2	3
Joint pain or recent arthritis	0	1	2	3	Feeling fatigued	0	1	2	3
Weight gain in waist	0	1	2	3	Insomnia (can't get to sleep)	0	1	2	3
Osteoporosis or bone pain in hips or low back	0	1	2	3	PMS symptoms	0	1	2	3
Rapid heart rate or palpitations	0	1	2	3	Migraines or cyclic headaches	0	1	2	3
ED TOTAL					EE TOTAL				

Hard to lose weight or swollen all over	0	1	2	3	Face is more pale and has more wrinkles	0	1	2	3
Very low energy or fatigue and exhaustion	0	1	2	3	Loss of sex drive	0	1	2	3
Dry and rough skin on face, arms, legs	0	1	2	3	Ongoing fatigue that worsens with activity	0	1	2	3
Dry, coarse hair and hair loss	0	1	2	3	Loss of muscle tone and less muscle mass	0	1	2	3
Low body temperature and always feeling cold	0	1	2	3	Dry eyes	0	1	2	3
Constipation or infrequent stools (<1/day)	0	1	2	3	Loss of height with age	0	1	2	3
Puffiness on face or under the eyes (bags)	0	1	2	3	Loss of body hair, especially arms, legs, face	0	1	2	3
Apathetic or lack of interest in anything	0	1	2	3	Cellulite and varicose veins on legs	0	1	2	3
Slow reaction and poor concentration	0	1	2	3	Depression the whole day long	0	1	2	3
Brittle or slow growing nails	0	1	2	3	Indecisiveness and less self-confidence	0	1	2	3
thD TOTAL					TD TOTAL				