Mary Gilbertson Wellness

Health History Form

Date:

All questions in this questionnaire are strictly confidential and will become part of your medical record.

Name:	__ M __ F	**AGE:**
Address:		**DOB:**
Home Phone:	**Cell Phone:**	**Work:**
City/State/Zip:		**Fax:**
Email Address:		
Occupation:		
Marital status: __ Single __ Partnered __ Married __ Separated __ Divorced __ Widowed		

# of Children:	**Ages of Children:**
Height:	**Weight:**
Referred by:	
WOMEN ONLY	
# of Births:	**Complications:**
# of Miscarriages:	**C-Sections:**
Menopause:	**Other:**

Present Complaint or Illness and Duration

***List any complications, infertility, ovulation or menses issues here.**

SURGERIES		
Year	**Reason**	**Hospital**

ACCIDENTS		
Year	**Reason**	**Hospital**

MEDICAL HISTORY: Check any disease which you or your immediate relatives have had.

	Arthritis	Asthma	Cancer	Diabetes	Epilepsy	Glaucoma	Gout	Hypertension	Hypothyroid	Kidney	Neurological	Stomach	Ulcers	Periodontal	Tuberculosis	Osteoporosis	Obesity	Heart/Stroke
Relatives																		
You																		
Father																		
Mother																		
Brothers																		
Sisters																		
Spouse																		
Children																		
Grandparents																		

VITAMINS, MINERALS, HERBS, SUPPLEMENTS, ETC.		
Name	**Strength**	**Frequency Taken**

PRESCRIPTION DRUGS		
Name	**Strength**	**Frequency Taken**

ALLERGIES	
Cause or Medication	**Reaction You Had**
Environmental	
Foods	

HEALTH QUESTIONS		
How much coffee do you drink:	Cups per week:	Decaf or Regular:
How much tea do you drink:	Cups per week:	Decaf or Regular:
How much alcohol do you drink:	Drinks per day:	Drinks per week:
What is your relationship with sugar? Often: Binge: Moderately: Rarely: None: Binge: Daily: Weekly:		
Do you exercise regularly?		
If so, what does a typical week look like?		
Do you smoke cigarettes?	If so, how much?	Did you ever smoke?
Do you use artificial sweeteners?	If so, which one?	How much?
How do you relax?		

CHECK ANY OTHER ILLNESSES YOU HAVE OR HAVE HAD. P = past or C = current							
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.							
___	Abscesses	____	Diverticulitis	____	Herniated Disc	___	Numbness
___	Acne	____	Drug Addiction	____	Herpes	___	Pancreatitis
___	Aids	____	Ear Infections	____	High Blood Pressure	___	Persistent Cough
___	Alcoholic	____	Eczema	____	Hives	___	Pneumonia
___	Allergies	____	Emphysema	____	Insomnia	___	Polio
___	Alopecia/Hair Loss	____	Endometriosis	____	Jaundice	___	Psoriasis
___	Anemia	____	Excessive Fatigue	____	Kidney Stones	___	Rheumatic Fever
___	Attempt Suicide	____	Eye Disease	____	Liver Disease	___	Rheumatoid Arthritis
___	Arteriosclerosis	____	Fainting or Dizzy Spells	____	Low Blood Pressure	___	Scarlet Fever
___	Back Problems	____	Gall Stones	____	Lupus	___	Sciatica

___	Benign Breast Tumor	____	Gastritis	____	Major Surgery	___	Skin Ulcers
___	Bleeding Gums	____	Gingivitis	____	Malaria	___	Skipped Heart
___	Bronchitis	____	Goiter	____	Measles	___	Stroke
___	Candida Albicans	____	Gonorrhea	____	Mononucleosis	___	Syphilis
___	Cataracts	____	Hay Fever	____	Multiple Sclerosis	___	Thyroid Disease
____	Chest Pains	____	Hearing Problems	____	Mumps	____	Ulcerative Colitis
____	Chicken Pox	____	Hemorrhoids	____	Myopia	____	Vision Problems
____	Cirrhosis	____	Hepatitis	____	Nervous Breakdown	Other:	
____	Crohn's Disease	____	Hernia	____	Nervousness		
____	Depression	____	Headaches	____	Neuralgia		
____	Diphtheria			____	Night Blindness		

How often do you have bowel movements?	Daily?	Weekly?
How often do you have constipation?	Or diarrhea	Or both
Have you ever worked in an environment where you were exposed to pesticides, chemicals, or heavy metals?		
WOMEN ONLY		
Do you still have menstrual periods?	Number of Days between periods?	Length?
Do you use contraceptive?	What type?	
Are you taking estrogen replacement therapy?		
Do you get up during the night to urinate?	If so, how often?	
MEN ONLY		
Do you get up during the night to urinate?	If so, how often?	
Are you having problems getting or maintaining an erection?		

Is there any other health information you wish to share with me before completing this form? If so, please list it here.

Thank you for taking the time to complete this health history. I look forward to working with you.

Mary