WHOLE | medicine

14127 Capri Dr, Suite 5A
Los Gatos, CA 95032
(408) 884-1972

Date: ____________________

Name: ______________________________________ Age: ______ Date of Birth: ______________

(first) (middle) (last)

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender: ☐ Male ☐ Female

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please take the time to carefully and thoroughly complete this health history questionnaire; you may consider making a copy for your records. Print all information and indicate areas of confusion with a question mark. Thank you.

When, where and from who did you last receive medical or health care? ______________________________

____

For what reason? ____

____

Please identify the health concerns that have brought you to this Clinic in order of importance below:

Condition	Duration/date of onset	Past Treatment
1.		
2.		
3.		
4.		
5.		

Are there traumatic events or other triggers that you can identify as having caused or clearly aggravated your health problems? ☐ Yes ☐ No

If yes, please identify: ____

Do you have any infectious diseases? ☐ Yes ☐ No

If yes, please identify: ____

Height: __________ Weight: __________ Currently: __________ Past Max: __________ When? __________

What is your most recent blood pressure reading? __________ / ______ When? __________

Childhood Illnesses

Please check any that you have had:

☐ Asthma ☐ Chicken Pox ☐ Measles (2 week)

☐ Mumps ☐ Polio ☐ Rheumatic Fever

☐ Roseola ☐ Rubella (German measles) ☐ Scarlet Fever/Diphtheria

☐ Whooping cough/Pertussus Other: ______________________________

Immunizations

Please check any that you have had:

☐ Chicken Pox ☐ Diphtheria ☐ Hepatitis B

☐ Pertussis ☐ Polio ☐ Rubella/Mumps

☐ Tetanus Other: ______________________________

Hospitalizations & Surgeries

Reason **When**

______________________________ ______________

______________________________ ______________

______________________________ ______________

X-Rays / CAT Scans / MRI's / NMR's / Special Studies

Reason **When**

______________________________ ______________

______________________________ ______________

______________________________ ______________

Medications

Please list any medications (prescribed and over-the-counter), vitamins, herbs and supplements you are currently taking:______________

____

Are you allergic to any foods, drugs, or other substances? ☐ Yes ☐ No

If so, please list and describe reaction:______________________________

What prior types of allergy testing have you had? (please check)

☐ Blood IgE Inhalant/Food ☐ Blood IgG Food ☐ Food Intolerance Testing

☐ Intradermal ☐ Kinesiology ☐ Scratch

Family History

Please list all family members who have any of the following: (include father, mother brothers, sisters, spouse and children)

☐ Anemia ☐ Arthritis ☐ Asthma

☐ Bleeding (easily) ☐ Cancer ☐ Diabetes

☐ Eczema ☐ Glaucoma ☐ Gout

☐ Hay fever/Hives ☐ Heart Disease ☐ High Blood Pressure

☐ Hyperthyroid ☐ Hypothyroid ☐ Kidney Disease

☐ Mental Illness ☐ Seizures/Epilepsy ☐ Stroke

☐ Tuberculosis Other: ______________________________

Please list cause of death and age for all immediate family members:

Cause of death	Relation	Age

Social History

Income sources: ____________________

Does income meet monthly expenses? ☐ Yes ☐ No

Have you traveled outside the US in the past year? ☐ Yes ☐ No

If yes, where? ____________________

Did you serve in the military? ☐ Yes ☐ No

If yes, when? ____________________

Where? ____________________

Discharge Status? ____________________

Health Habits

How often do you drink?

Wine____________ Beer____________ Other alcohol____________

Do you use tobacco or have you in the past? ☐ Yes ☐ No

Total years since you stopped smoking? ____________________

Do you now or have you in the past used marijuana or other drugs? ☐ Yes ☐ No

If yes, which ones, how often and for how long? ____________________

Have you ever been exposed to toxic chemicals, solvents or other possible toxins? ☐ Yes ☐ No

If yes please explain ____________________

Do you exercise? ☐ Yes ☐ No

If yes, what forms and how often? ____________________

How do you relax? ____________________

What are you interests or hobbies? ____________________

Which of the following do you do on a regular basis? (Please check all that apply)

☐ Bicycling ☐ Jogging ☐ Meditation

☐ Pilates ☐ Swimming ☐ Walking

☐ Weightlifting ☐ Yoga Other: ____________

Diet

How many meals do you generally eat each day? ☐ 1 ☐ 2 ☐ 3 ☐ More than 3

Where do you usually buy your food? ____________________

Who cooks the meals you eat? ____________________

List the primary foods included in your diet

Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________

List the foods you exclude from your diet ____________________

List any of the following (and relative amounts) eaten regularly by you. Coffee, caffeinated teas, highly seasoned foods, processed foods, preservatives, refined foods and other foods you suspect may be harmful to your health:

____

List any foods you crave, regardless of their nutritional value (include sweets, chocolate, salty, sour, spicy, bread, rich/fatty foods, etc.):

____

List any foods to which you have a bad reaction and describe the reaction: ____

____

How much water do you drink each day? ____

Are you thirsty? ☐ Yes ☐ No

What temperature do you prefer your drinks? ☐ Hot ☐ Cold ☐ Room Temperature

Are you satisfied with your diet as it is now? ☐ Yes ☐ No

If no, why not? ____

Personal Care

Which of the following do you use on a regular basis?

☐ Aromatherapy
☐ Clay packs
☐ Colonic or enema
☐ Cosmetics
☐ Dry brushing of skin
☐ Electric hairdryer
☐ Hair spray
☐ Hot tub/bath
☐ Mineral bath
☐ Sauna
☐ Steam
Other: ______________________

Sleep

Do you have trouble falling asleep? ☐ Yes ☐ No

If so, what keeps you up? ____

Do you sleep straight through the night? ☐ Yes ☐ No

If not, what time do you wake up? ____

How long do you stay awake? ____

How many hours per night do you generally sleep? ____

Do you wake feeling refreshed? ☐ Yes ☐ No

Is there a position you cannot sleep in? ☐ Yes ☐ No

If yes, which? ____

Environmental Exposures

Which of the following do you routinely use at home?

☐ Air conditioning
☐ Computer screen
☐ Electric blanket
☐ Electric heat
☐ Feather pillow
☐ Forced air
☐ Gas heat
☐ Heated waterbed
☐ Microwave
☐ Oil heat
☐ Radiant heat
☐ Wood stove

Other: ____

Are your home and/or work environments well ventilated? ☐ Yes ☐ No

Are your home or work environments excessively damp? ☐ Yes ☐ No

Are there unusual or unpleasant smells in your home or living environment? ☐ Yes ☐ No

When were the ducts in your home last cleaned? ____

Occupation: ____

Hours per week ____

Do you enjoy your work? ☐ Yes ☐ No

Why or why not? ______________________________

Which of the following are most bothersome to you or are known allergies?

- ☐ Car fumes
- ☐ Change in weather:
- ☐ Chemicals (specify):
- ☐ Dampness
- ☐ Dryness
- ☐ Dust
- ☐ Fluorescent light
- ☐ Grasses/weeds
- ☐ Lack of sunlight
- ☐ Mold
- ☐ Perfume
- ☐ Pets
- ☐ Poor ventilation
- ☐ Smoke
- ☐ Sunlight
- ☐ Tree pollens

Season: ____________________

Other: ______________________________

Do you get outdoors daily, even in winter? ☐ Yes ☐ No

Integument / Skin

Please check any symptoms that you experience now and any that you have experienced in the past:

Now	Past		Now	Past		Now	Past	
☐	☐	Bumpy	☐	☐	Color changes	☐	☐	Cysts
☐	☐	Dry	☐	☐	Hives (cause ________________)	☐	☐	Itchy
☐	☐	Light or dark patches	☐	☐	Loss of hair	☐	☐	Moles
☐	☐	Pits	☐	☐	Rashes	☐	☐	Ridges
☐	☐	Rough	☐	☐	Scaly	☐	☐	Scars (located________________)
☐	☐	Warts	☐	☐	White spots on nails			

Hematopoetic, Immune

Please check any that you experience now and any that you have experienced in the past:

Now	Past		Now	Past		Now	Past	
☐	☐	Anemia	☐	☐	Bleeding easily	☐	☐	Bleeding from unusual places
☐	☐	Chronic infections	☐	☐	Difficulty stopping bleeding	☐	☐	Fatigue
☐	☐	Fluid retention	☐	☐	Painful lymph nodes	☐	☐	Slow wound healing
☐	☐	Swollen glands						

Date of last blood test___________ Please list abnormalities: ____________________

Endocrine

Please check any that you experience now and any that you have experienced in the past

Now	Past		Now	Past		Now	Past	
☐	☐	Chronic fatigue	☐	☐	Cold hands or feet	☐	☐	Dizziness
☐	☐	Dry or scaly skin	☐	☐	Easily stressed	☐	☐	Headache
☐	☐	Hypoglycemia	☐	☐	Increased hunger	☐	☐	Increased thirst
☐	☐	Insomnia	☐	☐	Irritable/restless	☐	☐	Mental slowness
☐	☐	Night sweats	☐	☐	Sensitive to cold	☐	☐	Sensitive to heat
☐	☐	Thinning hair	☐	☐	Unexplained weight loss/gain	☐	☐	Weakness

Endocrine

Please check any that you experience now and any that you have experienced in the past:

Now	Past		Now	Past		Now	Past	
☐	☐	Diabetes Mellitus	☐	☐	Feeling Hot or Cold	☐	☐	Hyperthyroid
☐	☐	Hypoglycemia	☐	☐	Hypothyroid	☐	☐	Night Sweats

Head, Eye, Ear, Nose & Throat

Please check any that you experience now and any that you have experienced in the past:

Now Past	Now Past	Now Past
☐ ☐ Bad breath	☐ ☐ Bitter taste	☐ ☐ Bleeding gums
☐ ☐ Chronic strep throat	☐ ☐ Chronic tonsillitis	☐ ☐ Cold sores
☐ ☐ Difficulty swallowing	☐ ☐ Discharge from ears	☐ ☐ Dizziness
☐ ☐ Double vision	☐ ☐ Eye pain/strain	☐ ☐ Fainting
☐ ☐ Frequent sore throats	☐ ☐ Hay Fever	☐ ☐ Hearing problems
☐ ☐ Light hurts eyes	☐ ☐ Loss of smell	☐ ☐ Loss of teeth
☐ ☐ Mercury fillings	☐ ☐ Nasal scabs/sores	☐ ☐ Nose bleeds
☐ ☐ Pain in ear	☐ ☐ Persistent hoarseness	☐ ☐ Poor eyesight
☐ ☐ Ringing in ears (pitch?)	☐ ☐ Seizures/convulsions	☐ ☐ Sensitive to noises
☐ ☐ Sensitivity to noise	☐ ☐ Severe headaches	☐ ☐ Sinus problems
☐ ☐ Sore mouth or tongue	☐ ☐ Speech difficulties	☐ ☐ Tearing or dry eyes
☐ ☐ Teeth Grinding	☐ ☐ TMJ/Jaw Problems	

Respiratory

Please check any that you experience now and any that you have experienced in the past:

Now Past	Now Past	Now Past
☐ ☐ Asthma/Wheezing	☐ ☐ Chest congestion	☐ ☐ Chest pain while breathing
☐ ☐ Daily Cough	☐ ☐ Difficulty Breathing at Night	☐ ☐ Emphysema
☐ ☐ Frequent Common Colds	☐ ☐ Loss of voice	☐ ☐ Persistent Cough
☐ ☐ Pleurisy	☐ ☐ Pneumonia	☐ ☐ Shortness of Breath
☐ ☐ Tuberculosis	☐ ☐ Unexplained fever	

Other Respiratory Problems: ______________________________

Have you ever been exposed to TB (tuberculosis?) ☐ Yes ☐ No

Have you ever tested positive? ☐ Yes ☐ No

Do you have a history of (please check): ☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Tonsillitis

Cardiovascular

Please check any that you experience now and any that you have experienced in the past:

Now Past	Now Past	Now Past
☐ ☐ Heart Beating Fast	☐ ☐ Heart Beating Slow	☐ ☐ Chest Pain
☐ ☐ Fibrillation	☐ ☐ Heart Disease	☐ ☐ Heart Murmurs
☐ ☐ High Blood Pressure	☐ ☐ Leg pain when walking	☐ ☐ Murmur (type?) ______________
☐ ☐ Palpitations/Fluttering	☐ ☐ Rheumatic Fever	☐ ☐ Skipping beat
☐ ☐ Stroke	☐ ☐ Swelling of Ankles	☐ ☐ Varicose Veins

Neurologic

Please check any that you experience now and any that you have experienced in the past:

Now Past	Now Past	Now Past
☐ ☐ Loss of Balance	☐ ☐ Numbness/Tingling	☐ ☐ Paralysis
☐ ☐ Seizures/Epilepsy	☐ ☐ Vertigo/Dizziness	

Gastrointestinal

Please check any that you experience now and any that you have experienced in the past:

Now	Past		Now	Past		Now	Past	
☐	☐	Abdominal Pain	☐	☐	Constipation & diarrhea	☐	☐	Appetite decrease
☐	☐	Appetite increase	☐	☐	Bad breath	☐	☐	Belching
☐	☐	Black Stools	☐	☐	Blood in stool	☐	☐	Change in bowel movements
☐	☐	Changes in Appetite	☐	☐	Diet but fail to lose weight	☐	☐	Fat or greasy food distress
☐	☐	Eat but fail to gain weight	☐	☐	Epigastric Pain	☐	☐	Foul odored Stools
☐	☐	Gall Bladder Disease	☐	☐	Green Stools	☐	☐	Heartburn
☐	☐	*Hemorrhoids*	☐	☐	Hepatitis B or C	☐	☐	Indigestion after eating
☐	☐	Irritable when hungry	☐	☐	Liver Disease	☐	☐	Nausea
☐	☐	Passing Gas / Bloating	☐	☐	Strain at defecation	☐	☐	Sweets or alcohol craving
☐	☐	Symptoms worse with stress	☐	☐	Ulcers	☐	☐	Undigested matter in Stools
☐	☐	Upset from acid foods	☐	☐	Vomiting	☐	☐	Yellow Stools
☐	☐	Nervous, shaky or headache relieved by sweets						

Genito-Urinary Tract

Please check any that you experience now and any that you have experienced in the past:

Now	Past		Now	Past		Now	Past	
☐	☐	Blood in Urine	☐	☐	Difficulty holding urine	☐	☐	Difficulty starting urine
☐	☐	Frequent Urination	☐	☐	Frequent Urination at Night	☐	☐	Frequent UTI
☐	☐	Heavy Flow	☐	☐	Impaired Urination	☐	☐	Kidney Disease
☐	☐	Kidney Stones	☐	☐	Painful Urination			

Female Reproductive

Please check any that you experience now and any that you have experienced in the past:

Now	Past		Now	Past		Now	Past	
☐	☐	Breast Lumps/Tenderness	☐	☐	Difficulty Conceiving	☐	☐	Genital eruptions
☐	☐	Low libido	☐	☐	Menopausal Symptoms	☐	☐	Nipple Discharge
☐	☐	Painful sex	☐	☐	Pelvic pain	☐	☐	Seldom orgasm
☐	☐	Vaginal Discharge						

Age of First Menses: ____________________ Length of Cycle: ____________________

# of Days of Menses: ____________________ Date of last period: ____________________

# of Abortions: ____________________ # of Miscarriages: ____________________

# of Pregnancies: ____________________ # of Live Births: ____________________

Birth Control Type: ____________________

Have you ever used birth control pills? ☐ Yes ☐ No

If so, how long? ____________________

Where there any side effects? ____________________

Have you ever had problems with infertility? ☐ Yes ☐ No

If yes, please explain ____________________

Have you had complications with pregnancy? ☐ Yes ☐ No

If yes, please explain ______________________________

Age at menopause onset ______________________________

Date of last PAP smear:________________ Was it normal? ☐ Yes ☐ No

Please check all menstrual and premenstrual-related symptoms that you experience now and any that you have experienced in the past:

Now Past	Now Past	Now Past
☐ ☐ Abdominal bloating	☐ ☐ Anxiety	☐ ☐ Bleeding Between Cycles
☐ ☐ Breast tenderness	☐ ☐ Clotting	☐ ☐ Confusion
☐ ☐ Craving for sweets	☐ ☐ Crying	☐ ☐ Depression
☐ ☐ Dizziness or fainting	☐ ☐ Fatigue	☐ ☐ Forgetful
☐ ☐ Headache	☐ ☐ Heart pounding	☐ ☐ Heavy Flow
☐ ☐ Increased appetite	☐ ☐ Insomnia	☐ ☐ Irregular Cycles
☐ ☐ Irritability	☐ ☐ Mood changes	☐ ☐ Nervous tension
☐ ☐ Painful Periods	☐ ☐ Scanty/absent menses	☐ ☐ Swelling extremities
☐ ☐ Weight gain		

Male Reproductive

Please check any that you experience now and any that you have experienced in the past:

Now Past	Now Past	Now Past
☐ ☐ Infertility	☐ ☐ Penile Discharge	☐ ☐ Prostrate Problems
☐ ☐ Sexual Difficulties	☐ ☐ Testicular Pain/Swelling	

Date of last prostate exam: _______________ Was it normal? ☐ Yes ☐ No

Musculoskeletal

Please check any that you experience now and any that you have experienced in the past:

Now Past	Now Past	Now Past
☐ ☐ Arm Pain	☐ ☐ Leg Pain	☐ ☐ Low Back Pain
☐ ☐ Mid Back Pain	☐ ☐ Muscle Spasms/Cramps	☐ ☐ Neck/Shoulder Pain
☐ ☐ Upper Back Pain	☐ ☐ Joint Pain (location ____________)	☐ ☐ Swelling (location ____________)
☐ ☐ Stiffness (location_____________)	☐ ☐ Injuries (location _____________)	

Mental / Emotional

Please check any that you experience now and any that you have experienced in the past:

Now Past	Now Past	Now Past
☐ ☐ Afraid to be alone	☐ ☐ Anger/frustration	☐ ☐ Anxiety or Fear
☐ ☐ Decreased concentration	☐ ☐ Depression	☐ ☐ Despair/discontent
☐ ☐ Excessive Worry	☐ ☐ Loneliness	☐ ☐ Memory difficulty
☐ ☐ Mental Tension	☐ ☐ Mood Swings	☐ ☐ Nervousness
☐ ☐ Prefer to be alone	☐ ☐ Restlessness	☐ ☐ Suicidal thoughts

Have you experienced any major traumas? ☐ Yes ☐ No

If yes, explain: ______________________________

Other

Any obstacles to perfect health, which have not been covered? ______________________________