Health Always
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Solutions for Wellness

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Medical History Form

Name:		
Gender:	DOB:	Age:
Address:		
City:	State:	Zip:
Contact Information:		
Home #	Work #	Cell #
Email Address:		

Height	Weight
List the main problems you wish to address:	

Do you have any medical conditions? *Please check all that apply*		
Heart Disease	Blood clotting problems	Other Conditions:
High Cholesterol or lipids	Diabetes	
High Blood Pressure	Arthritis or joint problems	
Cancer	Depression	
Ulcers	Epilepsy	
Thyroid Disease	Headaches/migraines	
Hormonal Related Issues	Immune system disorders	
Lung condition/ Asthma		

Please list and note the year of any surgeries that you have had:

MEDICATIONS

Please list all current medication(s):

Medication name	Strength	Date Started	How often per day

Do you have a family history of any of the following? *(relation with family member)*			
Skin Conditions	No	Yes	Family Member(s)____________________
Obesity	No	Yes	Family Member(s)____________________
Lung Disease	No	Yes	Family Member(s)____________________
Cancer	No	Yes	Family Member(s)____________________
Liver Disease	No	Yes	Family Member(s)____________________
Alcohol/Drugs	No	Yes	Family Member(s)____________________
Heart Disease	No	Yes	Family Member(s)____________________
Neurological	No	Yes	Family Member(s)____________________
Depression	No	Yes	Family Member(s)____________________
Diabetes	No	Yes	Family Member(s)____________________

Nutritional/ Natural Supplements: *Please identify & check all that you are using:*
______Vitamins ____
______Minerals ____
______Herbs ____
______Enzymes____
______Nutrition/protein supplements____
______Others____

Allergies: *please check all that apply:*		
_____No known allergies	_____Penicillin	______Others: *please list*
_____Codeine	_____Pet Allergies	
_____Sulfa drug	_____Seasonal Allergies	
_____Morphine	_____Nitrate Allergies	
_____Aspirin		
_____Food Allergies		
_____Dye Allergies		
Please describe the allergic reaction you experienced:		

The three most important factors to consider in addressing your wellness and the healing process are: Environment, Diet, and Lifestyle. The balance of this form is designed to focus on an evaluation of these three essential areas.

ENVIRONMENT

WORK HISTORY / ENVIRONMENT

Current occupation ________________________________ How long? __________

Past occupations _________________________________ How long? __________

Comments ____

____

Do you think your work has anything to do with your symptoms? ________________

List any chemicals, metals, dusts, molds, or fumes to which you are repeatedly exposed

____

____

HOME HISTORY/ENVIRONMENT *please check all that apply :*

__ House # years old _______ __ Mobile home __ Apartment

How long lived there? ________ Current Pets __________________________

Garage: __ attached __ detached __ breezeway

Location: __ In wooded area __ On a farm __ Near industry __ Near Golf Course

__ Crawl Space __ Mold issues __ Basement damp/musty __ ever flooded

__ Radon issue __ Smoking in house __ Carpets __ Recent Pesticides used

__ Hobbies ___________________________ __ Recent Remodeling, Painting

Drinking water: __ Well, __ Uranium issue __ City __ Filter, brand? ____________

Do you have or had a toxic exposure in your home? __ Please list: _________________

____

Do any home products bother you? ____

____

D I E T

1. Do you follow a special diet? __ what type? ________________________________

   Rotation __ Paleo __ Vegetarian __ Organic __

2. What is your primary source of water? __ Tap __ Well __ Bottled _ Filtered

3. How often do you consume fish per week? _________________________

4. What kinds of fish do you eat?_______________________________________

5. How many slices of bread do you eat daily?________ Kind of Bread?_________

6. How many glasses of milk daily?_____ Kind of milk consumed?______________

7. How many cups of coffee per day? _____ Decaf _____ Regular _____ Organic

8. How many cups of tea per day? _____ Decaf _____ Regular _____ Organic

9. Is margarine or butter used most of the time?____________________________

10. What kind of oil do you cook with? ___________________________________

11. Are most meals consumed at home, restaurants or fast food? _______________

12. Are sugar substitutes used? _________ Which ones? _____________________

13. Are you or have you ever been a vegetarian? _____________________________

14. Do you eat wild local game (venison)? __________________________________

15. What are your favorite deserts? ______________________________________

16. How Frequently do you have Bowel Movements?

    Daily __ Every 2-3 Days __ Weekly __

    Other? (explain) ____

Typical Meals

Please fill out the following with what your diet typically consits of on an average day. Please be as specific (and honest) as possible!

BREAKFAST ____

____

____

MORNING SNACK ____

____

LUNCH ____

____

____

AFTERNOON SNACK ____

____

DINNER ____

____

____

EVENING SNACK ____

____

LIFESTYLE

Overall how would you rate your health?	Excellent	Good	Fair	Poor
How do you rate your energy level?	High	Fairly High	Low	Poor
How do you rate your stress level?	High	Tolerable	Good	Ideal
Do you exercise at least once a week?	Yes	No		
How often do you exercise every week?	Once	Twice	Three times or more	
What type of exercise do you do?	Aerobic	Anaerobic/Strengthening	Both	

HABITS:

Do you smoke? __ Yes __ No If yes, how many packs a day? ____________________

If you quit, How long ago? ____

Are you exposed to 2nd hand smoke? __ Yes __ No

Do you use alcohol? __ Yes __ No If yes, how often do you drink? ________________

Have you ever had problems with drug use? ______________________________________

Have you had the COVID vaccine? __ Yes __ No If yes, when? __________________

How many booster shots? _______

Thank you for taking the time to carefully complete this form.

It is the beginning of your process of healing and good health!