CONFIDENTIAL MEDICAL/HEALTH PROFILE - FEMALE

Name____ Date____________________
Address____ DOB___________________
City/State/Zip____ Age_________Sex: ___M___F
Phone: Work_________________________Res________________ Height________Weight_______
Cell Phone__________________________________ Email_________________________________
Employer__________________________________ Occupation______________________________
Referred by__________________________________ **Blood Type** ________________

Iris Color: __Lymphatic __Biliary __Hematogenic Structure______________________________

How do you rate your overall general health? ____Excellent ____Good ____Fair ____Poor
Are you under a physician's care now?___Yes ___No For what:_______________________________
Primary Care Physician____

MEDICATIONS: (Use another sheet or write on back if more space is needed)
Name of Medication Dosage (strength) Frequency

____
____
____
____
____
____
____

Do you take any street drugs? ___Yes ___No Please list:_________________________________

Reason for visit: Please list your most important present health concerns in order of significance:
1____ 5____________________________________
2____ 6____________________________________
3____ 7____________________________________
4____ 8____________________________________

History of Surgery: (List type and approximate date and age)

____
____
____
____

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CLIENT ____

Please list any significant physical trauma (accident or injury, and at what age)

____
____
____
____

Please list any significant mental/emotional trauma (and at what age)

____
____
____
____

How would you describe your current emotional condition?

____
____
____

Do you have energy swings/surges during the day? ___Yes ___No Please explain:__________________

____

Frequency of bowel movements: ______per day or _____per week ___loose ___normal ___hard

Any bowel issues?____

____

Are you taking birth control pills? ___Yes ___No If yes, kind______________________

Are you taking hormone replacements ___Yes ___No If yes, kind_________________________________

____

Are you pregnant: ___Yes ___No If yes, due date:____

FAMILY HISTORY - CAUSE OF DEATH (Blood Relatives)

	Age, if alive	Age at Death	Cause of Death
MOTHER	_______	________	______________________________
Maternal GM	_______	________	______________________________
Maternal GF	_______	________	______________________________

Longevity present in other familiy members ____

	Age, if alive	Age at Death	Cause of Death
FATHER	_______	________	______________________________
Paternal GM	_______	________	______________________________
Paternal GF	_______	________	______________________________

Longevity present in other family members ____

Other significant factors:____

____
____
____

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PERSONAL HEALTH HISTORY

(Please check all that apply) **CLIENT** ______________________________

SKIN
- ☐ Rashes
- ☐ Eczema, Hives
- ☐ Acne, Boils
- ☐ Itching
- ☐ Color change
- ☐ Lumps
- ☐ Warts
- ☐ Night Sweats

EYES
- ☐ Impaired Vision
- ☐ Glasses, Contacts
- ☐ Eye Pain
- ☐ Tearing, Dryness
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Cataracts

EARS
- ☐ Imparied Hearing
- ☐ Ringing
- ☐ Earache
- ☐ Dizziness

NOSE & SINUSES
- ☐ Frequent Colds
- ☐ Nose Bleeds
- ☐ Stuffiness
- ☐ Hayfever
- ☐ Sinus Problems

MOUTH & THROAT
- ☐ Frequent Sore Throat
- ☐ Sore Tongue
- ☐ Gum problems (periodontal)
- ☐ Hoarseness
- ☐ Bad Breath

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Broken Bones
- ☐ Joint Pain, Stiffness
- ☐ Muscle Spasms, Cramps
- ☐ Weakness

RESPIRATORY
- ☐ Prolonged Cough
- ☐ Sputum
- ☐ Spitting up Blood
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Emphysema
- ☐ Difficulty Breathing
- ☐ Pain on Breathing
- ☐ Shortess of Breath
  - ___at night
  - ___lying down
- ☐ Tuberculosis

CARDIOVASCULAR
- ☐ Angina, Chest Pain
- ☐ Angioplasty
- ☐ Arrhythmia
- ☐ Arteriosclerosis
- ☐ Artificial Heart Valves
- ☐ Atherosclerosis
- ☐ Blood Pressure - High
- ☐ Blood Pressure - Low
- ☐ Bypass Surgery
- ☐ Cardiac Pacemaker
- ☐ Congenital Heart Lesions
- ☐ Coronary Stent
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Palpitations, Fluttering
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Swelling in Ankles

BLOOD
- ☐ Anemia
- ☐ Easy bleeding/bruising
- ☐ Leukemia

URINARY
- ☐ Frequency at Night
  - ___times per night
- ☐ Increased Frequency
- ☐ Frequent Infections
- ☐ Inability to hold urine
- ☐ Kidney Stones
- ☐ Pain with urination

FEMALE REPRODUCTIVE

Age menses began_____
Age menses ended_____
Average number of days ____
Length of Cycle_______ days
Number of pregnancies______
Number of live births _______
Number of miscarriages _____
Number of abortions________
Sexually active ___Y ___N
Do self breast exam? ___Y___N

- ☐ Hysterectomy
- ☐ Ovarian Cysts
- ☐ Difficulty conceiving
- ☐ Bleeding between periods
- ☐ Irregular cycles
- ☐ Pain during intercourse
- ☐ Painful menses, cramps
- ☐ Excessive flow
- ☐ Menopausal Symptoms
- ☐ Venereal Disease
- ☐ Lumps in breast
- ☐ Pain, Tenderness in Breast
- ☐ Nipple Discharge

GASTROINTESTINAL
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Change in thirst
- ☐ Change in appetite
- ☐ Nausea/vomiting
- ☐ Vomiting blood
- ☐ Blood in stool
- ☐ Bowel move ___ day/wk
- ☐ Belching, pass gas
- ☐ Jaundice
- ☐ Liver disease

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CLIENT ______________________________

PERIPHERAL VASCULAR
- ☐ Chill easily
- ☐ Circulatory Problems
- ☐ Cold Hands/Feet
- ☐ Deep leg pain
- ☐ Thrombophlebitis
- ☐ Varicose Veins

ENDOCRINE
(Adrenals, pancreas, parathyroid, pineal , pituitary, male/female sex glands, thymus, thyroid)
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Heat/Cold Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Diabetes
- ☐ Gallstones
- ☐ Low Blood Sugar/ Hypoglycemic

NEUROLOGIC
- ☐ Fainting
- ☐ Seizures
- ☐ Headache
- ☐ Head Injury
- ☐ Paralysis
- ☐ Muscle weakness
- ☐ Numbness, Tingling
- ☐ Loss of Memory

EMOTIONAL
- Anxiety
- Depression
- Mental Illness
- Mood Swings
- Nervousness
- Temper Problems
- Tension

SLEEP:
- ☐ Insomnia

HEAD & NECK
- ☐ Headaches
- ☐ Head injury
- ☐ Lumps, swollen glands
- ☐ Goiter
- ☐ Pain, stiffness

OTHER
- ☐ AIDS
- ☐ Allergies of any kind
- ☐ Cancer
- ☐ Drug/Alcohol Treatment
- ☐ Herpes
- ☐ Hepatitis
- ☐ HIV Positive
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Polio
- ☐ Psychiatric Treatment
- ☐ Radiation Therapy

OTHER:

DIETARY HABITS

Please desribe what you typically eat for each meal______________________

Breakfast______________________________

____

____

____

Lunch______________________________

____

____

____

Dinner______________________________

____

____

____

Snacks______________________________

____

____

Time you normally eat: Breakfast_________ Lunch___________ Dinner___________

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CLIENT____

LIFESTYLE HISTORY

Do you smoke? __Yes __No If yes, how many per day?__________How long?____________

Have you quit smoking? ___Yes ___No If yes, when ______________________________

Do you consume alcoholic beverages? ___Yes ___No

If yes: ___Wine ___Mixed Drinks ___Beer

How much and how often?____

SLEEP:

Average hours of sleep per night?______ Do you feel this is enough sleep? ___Y ___N

Describe your sleep: ___Unbroken ___I wake up ____ times per night

Do you awake rested? ___Y ___N If no, explain ______________________________

Describe any other difficulties or patterns with your sleep ______________________

____

____

Rate your energy level (5 being most energetic) 1 2 3 4 5

Rate your activity level:

___sedentary ___slightly active ___moderately active ___very active

STRESS

Rate your stress level (5 being most stressful) 1 2 3 4 5

Where does your stress come from: ____job ____family ___other (please explain)

____

How much discretionary time do you have in your life?_________________________

How much time do you take for yourself each day and how do you use it? _____________

____

Do you take vacations and if so, how often? __________________________________

Hobbies and leisure activities____

____

____

EXERCISE:

Do you exercise? ____Yes ____No

If yes, how many days per week?__________ How long each session? _______________

What type of exercise do you do?____

____

____

____

Do you have a religious affiliation? ___Y ___N

If yes, please indicate___________________________________

Are you open to being prayed with? ___Y ___N

How would you describe your spiritual life____________________________________

____

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CLIENT____

DIET/NUTRITION

Please indicate how many servings *PER DAY* you have of each of the following: *For fruits and vegetables a serving is approximately 1/2 cup*

Fruit __________________________________
Vegetables________________________________
Whole Grains, breads, cereals ____________________
Seeds/Nuts (i.e. pumpkin, sunflower, almonds, etc)__________________
Dairy (milk, cheese, yogurt, etc.) __________________

Please indicate how many servings *PER WEEK* you have of each of the following:

Meat (red, pork, lamb) ________________________
Lunchmeats ______________________________
Poultry (chicken, turkey) ______________________
Fish __________________________________
Shellfish________________________________

How much of the following to do you consume: (Indicate whether per day, week, etc.)

Regular Coffee____________________________
Decaffeinated Coffee_________________________
Do you use creamer? ___Y ___N Sweetener ___Y ___N
Tea__________________________________
_______Herbal _______Black _______Green
Colas/sodas______________________________
Sugar substitutes/artificial sweeteners used___________________________
Sweets (ice cream, cookies, cakes, pastries, candies, chocolate, etc.) What type and how often do you consume them?________________________________
____
How often do you eat out and what types of food?_______________________
____
How often do you eat fried foods?_______________________________
How often do you eat wheat products?______________________________
How much water do you drink per day?______________________________

PLEASE LIST SUPPLEMENTS YOU TAKE

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CHOLESTEROL

If known, please complete the following:

TOTAL CHOLESTEROL
Less than 200 (optimal) 200-239 (borderline high) 240 and above (high)
My total cholesterol is ______________________________

LDL/LOW DENSITY LIPOPROTEIN (Bad cholesterol)

My LDL cholesterol is ______________________________

HDL/HIGH DENSITY LIPOPROTEIN (Good cholesterol)

My HDL cholesterol is ______________________________

My HDL to Total Cholesterol Ratio is_______________

TRIGLYCERIDES

<150 (optimal) 150-200 (border/high) 200-400 (high) 400 and above (very high)
My Triglycerides are ________________________________

BLOOD PRESSURE

	Optimal	**Normal**	**High Normal**	**Hypertension**
Systolic	<120	<130	130-139	140 or higher
Diastolic	<80	<85	85-89	90 or higher

My blood pressure is _________________/__________________

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