Please print | This information will be contained in your confidential medical history | Please print

QUANTUM HEALTH NEUROCARE HEALTH HISTORY

Name (first, middle, last)	Age:	Today's Date:

PAST HISTORY

Please give names and dates

Major Illnesses: Medications:

Preferred Pharmacy

Previous hospitalizations or surgeries:

WELL BEING

Goals for Health:

What practices or activities do you use to sustain your health and well being?

Who do you turn to for support? Who are in your community?

Who lives in your household?

What causes stress for you?

DIET: ___Fast Food ___All American ___Vegetarian ___Balanced ___Other _____

SMOKING: Packs per day _____ Number of years _____ Years stopped _____ Pipe Cigar Chew

ALCOHOL: Never Occasional Moderate Heavy Alcohol Problem? Y N How much each week?

EXERCISE: Never Occasional Moderate Often Favorite types?

CAFFEINE: Coffee: _____ cups per day Tea: _____ cups per day

Height: _____ Weight _____ Weight at age 20 _____ Weight change last year: gain _____ lbs. lost _____ lbs.

OCCUPATIONAL EXPOSURES: _____ Asbestos _____ Other (describe)

DRUGS: Please check off drugs presently used and explain frequency of use (daily, weekly, etc.)

	Sleeping pill		Allergy medicine(s)		Blood thinner		Antibiotics
	Tranquilizer		Nose sprays		"Hard drugs"		Asthma medicine
	Anti Depressant		Cortisone/steroids		Marijuana		Shots
	Pain pill		Thyroid		Cocaine		Other(s) - Specify
	Diet pill		Heart pill		Laxative		
	Diabetes pill		Digitalis		Antacids		
	Estrogen hormone		Nitroglycerin		Decongestant		
	Birth control pill		Water pill (diuretic)		Vitamins		
	Insulin		Blood pressure pill		Iron		

ALLERGIES:

Food sensitivities:

Drug allergies/Type of reaction:

FAMILY HISTORY:	WHO:
Diabetes	
Heart disease	
High blood pressure	
Thyroid	
Stroke	
Cancer	
Alcoholism	

FAMILY HISTORY (cont.):	WHO:
Anxiety	
Depression	
CHILDRENS AGES/NAMES	

Please complete other side

QUANTUM HEALTH NEUROCARE HEALTH HISTORY - PAGE 2

PLEASE STATE YOUR CHIEF CONCERNS, MAIN PROBLEM, OR REASON(S) FOR SEEING THE DOCTOR:

SYSTEM REVIEW: Check if you have any symptoms or problems to any important or significant degree.

Tired all the time	Frequent chest colds	Indigestion	Sugar in urine
Don't feel well	Bronchitis	Heartburn	Hypoglycemia
Weakness	Pneumonia	Nervous stomach	Low blood sugar
Weight problem	Shortness of breath	Ulcers	Thyroid trouble
Fluid retention	Asthma/wheezing	Vomiting blood	DATE OF last urinary or bladder infection:
Lack of exercise	Hayfever	Black or bloody stools	
DATE OF LAST PHYSICAL EXAM:	Pleurisy	Rectal bleeding	Bladder problems
	Chest pain	Abdominal pain	Kidney infection
Headache	Heart trouble	Nervous or spastic colon	Kidney trouble
Migraine	Heart murmur	Colitis	Kidney stone
Fainting	Heart palpitation/racing	Diarrhea	Difficulty with urine
Dizziness	Chest tightness/pressure	Constipation	Protein or blood in urine
Epilepsy/seizure	Angina	Change in bowel habits	Sexually transmitted disease
Ear/hearing problem	Tire easily	Hemorrhoids	Skin rash
Ringing in the ears	Enlarged heart	Gall bladder trouble	Skin trouble
Stuffy nose	Rheumatic fever	Hepatitis	Allergy
Nose bleeds	Leg pain on walking	Liver disease	Food avoidance
Sinus trouble	Varicose veins	Hernia	Bleed or bruise easily
DATE OF LAST DENTAL EXAM:	Phlebitis	Food intolerance	Anemia
	Ankle/leg swelling	Nervous	Blood disease
Persistent hoarseness	DATE OF LAST CHEST X-RAY:	Tense/irritable	Infertility problem
Glasses		Bored	Sexual difficulty
Vision/eye trouble	DATE OF LAST Electrocardiogram:	Depressed	
Glaucoma		Trouble sleeping	**MEN ONLY:**
Cataract	Arthritis/joint pain	Relationship problems	Discharge from penis
DATE OF LAST EYE EXAM:	Gout	Job problems	Prostate trouble
	Neck pain	Personal problems	Stream weak or slow
Frequent cough	Back pain or trouble	Nervous breakdown	Swelling or pain in testes
Cough phlegm	Bursitis/tendentious	Psychiatrist seen	DATE OF VASECTOMY:
Cough blood	Swallowing trouble	High blood sugar	

WOMEN ONLY:

Age menstruation began: _____ Periods: ___Regular ___Irregular ___Painful ___Heavy Every_____days

Comments: Last menstrual period date(s):_____

Number of PREGNANCIES:___ Number of BIRTHS:___ Number of Miscarriages/Abortions:___

Dates of PREGNANCIES / outcome:

Type of birth control: _____ How Long?_____ IUD? ___Yes ___No Years inserted _____

Date of last mammogram _____ History of breast disease?

Symptoms of menopause?

(Additions to health history)

Please complete other side