MARIN GENERAL HOSPITAL

CENTER FOR INTEGRATIVE HEALTH & WELLNESS

Health History

Name: _____ Date: _____

Please list 5 major health concerns in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____

Family History	Self	Father	Mother	Sibling(s)	Children
Arthritis					
Asthma					
Cancer					
Allergies					
Heart trouble					
High blood pressure					
Stroke					
Diabetes					

If your complaint is pain related, please answer the questions below:

Rate the following on a scale of 0 to 10 (0 being none and 10 being the maximum possible):

Pain intensity right now _____

Usual pain intensity experienced over the past week _____

Amount that the pain interfered with daily activities _____

Frequency of Pain

- ☐ Continuous
- ☐ Several Times / Day
- ☐ Once / Day
- ☐ Three times / week
- ☐ Once / week

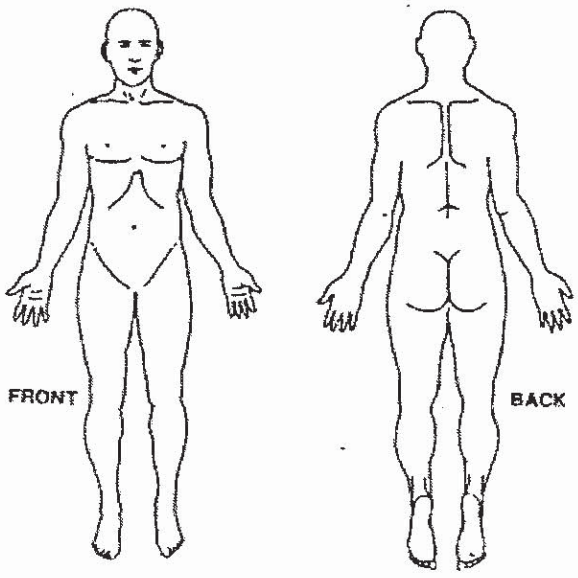
Duration of Pain

- ☐ Seconds
- ☐ Minutes
- ☐ Hours
- ☐ Days
- ☐ Continuous

Description of Pain (Check all that apply)

- ☐ Throbbing
- ☐ Gnawing
- ☐ Tender
- ☐ Cramping
- ☐ Hot
- ☐ Cold
- ☐ Dull
- ☐ Burning
- ☐ Heavy
- ☐ Aching
- ☐ Stabbing

PLEASE MARK YOUR AREAS OF PAIN



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Surgeries & Hospitalizations

Description	Date	Comments

Medications & Supplements

Please list all prescription medications and supplements you use. Include those that youonly use occasionally. Remember inhalers, eye drops, nose sprays, topical creams, and vitamins.

MEDICATIONS

Prescription Name	Purpose	How Long	Dose	How Often

SUPPLEMENTS

Supplement Name	Purpose	How Long	Dose	How Often

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Current / Recent	*Past*	**LIVER / GALLBLADDER**
■	■	Depression / Stress
■	■	Headaches / Migraines
■	■	Red / Dry / Itchy Eyes
■	■	Visual Problems / Blurred Vision
■	■	Dizziness
■	■	Gall Stones
■	■	Feeling of Lump in Throat
■	■	Clenching of Teeth at Night
■	■	Muscle Cramping / Twitching
■	■	Neck/Shoulder Pain / Tightness
■	■	Joint Pain
■	■	Poor Circulation
■	■	Soft / Brittle Nails
■	■	Bad Taste
■	■	Bad Breath
■	■	Do you crave: Sour
■	■	Irritability / Anger

		KIDNEY / URINARY BLADDER
■	■	Urinary Problems
■	■	Bladder Infection
■	■	Dropped Bladder
■	■	Incontinence
■	■	Lack of Bladder Control
■	■	Weakness / Pain in Low Back
■	■	Decreased Bone Density Feel
■	■	Cold Easily
■	■	Cold Hands / Feet
■	■	Low Sex Drive / Libido
■	■	Excess Sex Drive / Libido
■	■	Poor Memory
■	■	Loss of Hair / Grey Hair
■	■	Hearing Problems
■	■	Cavities
■	■	Hot Flashes / Night Sweats
■	■	Do you crave: Salt
■	■	Fear

		HEART / SMALL INTESTINE
■	■	Heart Palpitations
■	■	Chest Pain
■	■	High Blood Pressure
■	■	Low Blood Pressure
■	■	Insomnia / Sleep Problems
■	■	Vivid Dreams
■	■	Easily Startled
■	■	Do you crave: Bitter
■	■	Restlessness / Agitation

Current / Recent	Past	**LUNG / LARGE INTESTINE**
■	■	Bloody Cough
■	■	Dry Cough
■	■	Cough with Sputum
■	■	Nasal Discharge – Color: ■ White ■ Yellow ■ Green
■	■	Post Nasal Drip
■	■	Sinus Infection / Congestion
■	■	Itchy, Red or Painful Throat
■	■	Dry Mouth / Throat / Nose
■	■	Skin Rashes / Hives
■	■	Snoring
■	■	Shortness of Breath
■	■	Allergies / Asthma
■	■	Low Resistance to Illness
■	■	Sneezing
■	■	Mild Fever Comes & Goes
■	■	Smoke Cigarettes
■	■	Emphysema
■	■	Bronchitis
■	■	Black or Bloody Stools
■	■	Constipation
■	■	IBS
■	■	Diarrhea
■	■	Colitis / Spastic Colon
■	■	Do you crave: Pungent
■	■	Grief / Sadness

		SPLEEN / STOMACH
■	■	Body Heaviness
■	■	Hard to get up in the Morning
■	■	Muscles Often Feel Tired
	___	Energy Level: 1-10 (low to high)
■	■	Edema ■ Hands ■ Feet
■	■	Easily Brusing / Bleeding
■	■	Bad Breath
■	■	Nausea / Vomiting
■	■	Gas / Belching
■	■	Hemorrhoids
■	■	Diarrhea
■	■	Constipation
■	■	Abdominal Pain
■	■	Indigestion / Heartburn
■	■	Brain Foggy
■	■	Tendency to Gain Weight
■	■	Do you crave: Sweet
■	■	Over-thinking / Worry