Follow Up Health History

Holistic Einstein

219 Mill St., Rockport, ME 04856

Phone: 207-470-0499 Fax: 207-221-5707

Web: www.holistic-einstein.com Email: dan@holistic-einstein.com

Name:_____ Date of Birth:_____

Main Health Concerns Today:

1._____ 3._____

2._____ 4._____

For your most pressing health concern, please describe. If this is a chronic condition, please describe any changes since we last discussed it:

Your current symptoms, with as much detail as possible:

How this affects your life:

What makes this better or worse (medications, activities, therapies, supplements)

What testing or evaluations have been done:

What treatments you have tried for this problem, and how it worked:

Medical History

Please list any major health events since your last visit (hospitalizations, surgeries, new diagnoses).

Medications

Please list any medications or supplements you are taking (with dose). If it is easier, please bring a current list, or all your pill bottles, to each and every visit.

Allergies

Please list any new allergies since the last visit.

Lifestyle

Please list any changes since last time. This includes changes in diet, exercise, smoking/alcohol, job or living situation.

Review of Symptoms Check of any of these symptoms you have had in the last 2 weeks.

GENERAL:

☐ weight gain ☐ weight loss ☐ tired/weak ☐ dizzy/fainting ☐ fever/chills ☐ night sweats

HEAD:

☐ headaches ☐ head trauma ☐ hearing loss ☐ noise in ears ☐ earaches
☐ eye pain ☐ vision loss ☐ itchy eyes ☐ blurry vision ☐ cataracts
☐ painful teeth ☐ dentures ☐ bleeding gums ☐ nosebleeds ☐ runny/ stuffy nose
☐ sore throats ☐ swollen glands ☐ voice change ☐ room spins ☐ hearing aids
☐ wear glasses/contacts

RESPIRATORY:

☐ cough (w/plegm? w/blood?) ☐ wheezing ☐ short of breath ☐ other trouble breathing

HEART & CIRCLATION:

☐ chest pain ☐ heart races or skips beats ☐ short of breath after climbing steps
☐ high blood pressure ☐ legs swell ☐ short of breath while lying in bed
☐ varicose veins ☐ heart murmur ☐ legs hurt or cramp when walking
☐ dizzy when standing up ☐easy bruising/bleeding

DIGESTIVE:

☐ trouble swallowing ☐ heartburn ☐ poor appetite ☐ indigestion ☐ nausea
☐ vomiting (w/blood?) ☐ diarrhea ☐ constipation ☐ change in stool size or color
☐blood in stool ☐ hemorrhoids ☐ rectal pain ☐ excess belching or passing gas
☐ more than 5 bowel movements daily ☐ less than 1 bowel movement every other day

URINARY:

☐ burning with urination ☐ frequent urination ☐ slow/weak urine stream ☐ blood in urine
☐ accidentally lose urine ☐ kidney stones ☐ up multiple times at night to urinate
☐ frequent urinary infection

MUSCULOSKELETAL:

☐ pain in muscles ☐ pain in joints ☐ swollen joints ☐ redness around joints ☐ arthritis
☐ morning stiffness ☐ back pain ☐ gout ☐muscle spasms ☐ scoliosis

NEUROLOGICAL:

☐ blackouts ☐ seizures ☐ numbness or loss of sensation ☐ tingling or "pins and needles"
☐ tremors or other involuntary movements ☐ weakness in arms or legs ☐ trouble walking

SKIN:

☐ rash ☐ hair loss ☐ itching ☐ skin pain ☐ moles ☐ sores ☐ nail changes (specify:)

ENDOCRINE:

☐ heat or cold intolerance ☐ excessive sweating ☐ excessive thirst/hunger ☐excessive urination

PSYCHIATRIC

☐ nervousness ☐ tension ☐depression ☐ difficulty with memory ☐ hallucinations

MALE PATIENTS:

☐ lumps or pain in testicles ☐ erection problems ☐ discharge from penis ☐ poor sex drive

FEMALE PATIENTS:

☐ heavy bleeding ☐ painful periods ☐PMS ☐ painful intercourse ☐ vaginal sores or discharge
☐ breast lumps ☐ nipple discharge ☐ breast tenderness or pain ☐ hot flashes

Number of days period lasts: Date of last period: Are you pregnant?

BOTH SEXES:

☐ poor sex drive Birth Control Method: