Welcome to the office of Steve Hines, Board Certified Naturopath

At Hope Wellness Center, we recognize that you are wonderfully made and a marvelous work that must be analyzed on an individual basis. Steve Hines will assess your current health in a comprehensive manner. He will coordinate services between you and affiliated health care professionals to get you on the road to health.

Medical History Form:
Attached is a medical history form that will aid us on his review of your current condition:

- nutritional needs
- life style and stress level
- toxicology exposures
- infectious exposures
- hormonal symptoms

And an array of areas to determine the direction for your health care plan. Please fill it out as thoroughly as possible.

As a naturopath, his services are not billable through insurance. Some tests that may be necessary can be ordered by your physician and may be payable by your insurance.

Our office is located in the Village Shopping Center in San Angelo, Texas at:

Turtle Healing Band Tribal Community
Hope Wellness Center
2118 W. Beauregard Avenue
San Angelo, Texas 76901
325-947-5266

Type of appointments:

- One time new patient fee: $290 for 1 hour plus an initial $35 annual Nottaway Tribal Community membership fee.
- Follow-up visit: $180 for 1 hour
- To review test results: $90 for 30 minutes
- Phone Consult: $90 for 30 minutes

Please fax to **1-866-716-4945** or bring your health history form and any current test results or medical records you think might be helpful.

No-Show Policy:
If you do not cancel your appointment by 5:00 p.m. of the business day prior to your appointment, you will be billed for half of the appointment cost. We also require a credit/debit card at the time of scheduling an appointment in regards to our no-show policy.

Payments:
We accept MasterCard, Visa, and Discover credit cards, personal checks, or cash. Payment is due at time of service.

We look forward to serving you.
Steve Hines and Hope Wellness team
www.info@hopewellness.com

Hope Wellness Center
Health History

After completing the Health History form, please mail, e-mail, or fax it back to our office or bring it with you to your appointment. The cost of the initial consultation is $290.00. The duration of the initial consultation will be a minimum of one hour. In addition, the Nottaway Tribal Community membership fee will be $35.00.

Please note that our office policy states that **appointments canceled without 24 hours notice must be paid in full** before scheduling an additional visit.

Please bring all prescribed medicine, nutritional supplements and all other items you are currently taking along with any recent blood, saliva and urine tests results.

Our Office address and phone number is listed below;

Hope Wellness Center
Office of Steve Hines N.D., N.E.
2118 W Beauregard Ave.
San Angelo, Texas 76901

(325) 947-5266
(325) 223-2853 Fax
1 (866) 716-4945 E-

HEALTH HISTORY

DATE _____

NAME_____ SEX: ☐ M ☐ F
(LAST) (FIRST) (M.I.)

CURRENT BLOOD PRESSURE____/_____(REQUIRED)

ADDRESS_____
CITY_____STATE _____
ZIP _____
PHONE #_____
E-MAIL _____

AGE_____BIRTH DATE /___/____
BIRTHPLACE _____

HEIGHT _ WEIGHT_____LBS_____

☐ SINGLE ☐ MARRIED
☐ DIVORCED ☐ WIDOWED

YOUR OCCUPATION_____
_____
PREVIOUS OCCUPATIONS _____
_____
_____
_____

EDUCATION IN YEARS_____
HIGH SCHOOL _____
COLLEGE_____POST GRAD_____

STATES OR COUNTRIES WHERE YOU HAVE LIVED _____
_____
_____

WHAT ARE YOUR HOBBIES? _____
_____
_____

CURRENT HEALTH PROBLEMS

MAIN COMPLAINT _____
_____
_____
_____
_____

DESCRIBE IN DETAIL _____
_____
_____
_____
_____
DATE OF ONSET _____

HOW DID IT BEGIN? _____
_____
_____
_____
_____
_____

UNDER WHAT CIRCUMSTANCES DOES IT OCCUR?
_____
_____
_____
_____
_____

FREQUENCY _____
_____

SEVERITY & DURATION_____
_____
_____

WHAT TREATMENT HAVE YOU HAD FOR THIS PROBLEM?_____
_____
_____
_____
_____
_____

DIAGNOSED DISEASES
_____
_____
_____

HEALTH HISTORY

PRACTITIONERS NAME:
PRIMARY DOCTOR: _____
SPECIALIST _____
DIAGNOSTIC CODE(S)
_____ _____

LAST COMPLETE PHYSICAL EXAM
WHERE?_____
WHEN?_____
MEDICATION & DOSAGES: _____
_____
_____
_____
_____
_____
ANY OTHER PERTINENT INFORMATION:
_____
_____
_____
_____

LIST ANY OTHER MEDICAL PROBLEMS WITH DATE OF ONSET

DATE	PROBLEM
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

LIST ALL **MAJOR** ILLNESSES AND AGE THEY OCCURRED

AGE	ILLNESS
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

CHECK IF YOU'VE HAD:
☐ BIRTH DEFECTS
☐ FEEDING PROBLEMS
☐ BIRTH INJURIES

HAVE YOU EVER USED TOBACCO PRODUCTS
☐ YES ☐ NO
DO YOU USE TOBACCO NOW?
☐ YES ☐ NO
AMOUNT/FREQUENCY _____
☐ CIGARETTES
☐ PIPE
☐ CHEWING TOBACCO
☐ CIGARS

CHECK THE FOLLOWING IF YOU HAVE EVER HAD THESE VACCINATIONS

☐ SMALL POX	DATE_____
☐ POLIO	DATE _____
☐ MUMPS	DATE _____
☐ DPT OR TETANUS TOXIN	DATE_____

COMMUNICABLE DISEASES

CHECK DISEASES YOU HAVE HAD

☐ CHICKEN POX
☐ DIPHTHERIA
☐ GERMAN MEASLES
☐ GONORRHEA
☐ HEPATITIS
☐ HERPES SIMPLEX
☐ HIV
☐ INFLUENZA
☐ MEASLES
☐ MENINGITIS
☐ MONONUCLEOSIS
☐ MUMPS
☐ POLIO
☐ SCARLET FEVER
☐ SHINGLES
☐ SYPHILIS
☐ TUBERCULOSIS
☐ WHOOPING COUGH
☐ OTHER _____

ENDOCRINE

Check if you have or have had any of the following:

- ☐ Abnormal thirst
- ☐ Cramps in legs
- ☐ Diabetes or sugar in urine
- ☐ Enlarged thyroid/goiter
- ☐ Hypoglycemia
- ☐ Lack of appetite
- ☐ Noticeable increase in appetite
- ☐ Overactive thyroid
- ☐ Swelling
- ☐ Under-active thyroid
- ☐ Weight *gain* of more than five pounds in the last 12 months
- ☐ Weight *loss* of more than five pounds in the last 12 months☐ Spine

SURGICAL HISTORY

Check if you have ever had any of the following surgeries. Note the year performed.

	YEAR
☐ Appendectomy	
☐ Brain	
☐ Cancer	
☐ Ear	
☐ Eye	
☐ Gall bladder	
☐ Heart	
☐ Hemorrhoid	
☐ Hernia	
☐ Hysterectomy	
☐ Female other	
☐ Lung	
☐ Mastoid	
☐ Prostate	
☐ Male other	
☐ Skin	
☐ Stomach	
☐ Tonsillectomy	

HOSPITALIZATION

List reason, Length of stay, and dates.

	DATE

List medical emergencies that required treatment

	DATE

Check if you have you had X-rays of any of the following:

	DATE
☐ Chest	
☐ Kidneys	
☐ Colon	
☐ Skull	
☐ Extremities	
☐ Gall bladder	
☐ Stomach	
☐ Other _____	

Have you had any of the following?

☐ Bone scan	
☐ EKG	
☐ Brain scan	
☐ Stress EKG	
☐ Cat scan	
☐ Thyroid scan	

☐ Results _____

OTHER CONDITIONS

Check if you have experienced the following:

- ☐ Anaphylaxis
- ☐ Arthritis
- ☐ Convulsions
- ☐ Diabetes
- ☐ Emphysema
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Loss of consciousness
- ☐ Low blood pressure
- ☐ Paralysis
- ☐ Peptic ulcer
- ☐ Pneumonia
- ☐ Psychiatric care
- ☐ Severe dizzy spells
- ☐ Tuberculosis
- ☐ Severe reaction to allergy tests/shots

MEDICAL HEALTH HISTORY

FAMILY INFORMATION

FATHER

PRESENT AGE IF LIVING _____
GENERAL STATE OF HEALTH _____
IF DECEASED, AGE AT DEATH _____
CAUSE OF DEATH _____

MOTHER

PRESENT AGE IF LIVING _____
GENERAL STATE OF HEALTH _____
IF DECEASED, AGE AT DEATH _____
CAUSE OF DEATH _____

SISTERS & BROTHERS

ARTHRITIS (PLEASE NOTE IF BROTHER OR SISTER) □
ASTHMA
#1 _____
PRESENT AGE IF LIVING _____
GENERAL STATE OF HEALTH _____
IF DECEASED, AGE OF DEATH _____
CAUSE OF DEATH _____
#2 _____
PRESENT AGE IF LIVING _____
GENERAL STATE OF HEALTH _____
IF DECEASED, AGE AT DEATH _____
CAUSE OF DEATH _____
#3 _____
GENERAL STATE OF HEALTH _____
□ PRESENT AGE IF LIVING _____
IF DECEASED, AGE AT DEATH _____
CAUSE OF DEATH _____

SONS & DAUGHTERS

HYPOGLYCEMIA (PLEASE NOTE IF SON OR DAUGHTER) □
INDIGESTION
#1 _____
PRESENT AGE IF LIVING _____
GENERAL STATE OF HEALTH _____
IF DECEASED, AGE AT DEATH _____
CAUSE OF DEATH _____
#2 _____
PRESENT AGE IF LIVING _____
GENERAL STATE OF HEALTH _____
IF DECEASED, AGE AT DEATH _____
CAUSE OF DEATH _____
#3 _____
PRESENT AGE IF LIVING _____
GENERAL STATE OF HEALTH _____
IF DECEASED, AGE AT DEATH _____
CAUSE OF DEATH _____

CHECK WHAT APPLIES
□ HUSBAND
□ WIFE
□ PARTNER
PRESENT AGE IF LIVING _____
GENERAL STATE OF HEALTH _____
IF DECEASED, AGE AT DEATH _____
CAUSE OF DEATH _____

FAMILY HISTORY

CHECK ANY OF THE FOLLOWING THAT HAVE OCCURRED IN YOUR FAMILY

□ ALCOHOLISM
□
□ CANCER
□ CHRONIC FATIGUE
□ CONSTIPATION
□ DEPRESSION
□ DIABETES
□ DIARRHEA
□ DRUG ABUSE
□ DRUG ALLERGY
□ ECZEMA
□ EMPHYSEMA
□ EPILEPSY
□ HAY FEVER
□ HEART DISEASE
□ HIGH BLOOD PRESSURE
□ HIVES
□
□ INSANITY
□ INSECT ALLERGY
□ KIDNEY DISEASE
□ LOW BLOOD PRESSURE
□ MIGRAINE
□ NERVOUSNESS
□ PEPTIC ULCER
□ PSYCHIATRIC CARE
□ SCHIZOPHRENIA
□ STROKE
□ TUBERCULOSIS
□ VERTIGO
□ OTHER_____
TYPE OF CANCER _____
_____

MEDICAL HEALTH HISTORY

EYES

CHECK ANY OF THE FOLLOWING THAT YOU HAVE EXPERIENCED

- ☐ BLOODSHOT
- ☐ BLURRED VISION
- ☐ BURNING
- ☐ CATARACTS
- ☐ CRUSTY LIDS
- ☐ DARK CIRCLES
- ☐ DRYNESS
- ☐ FLOATERS
- ☐ FREQUENT BLINKING
- ☐ GLAUCOMA
- ☐ GRANULATED LID
- ☐ IRRITATED
- ☐ ITCHING
- ☐ MUCUS IN EYE
- ☐ PUFFY UNDER EYE
- ☐ SENSITIVE TO LIGHT
- ☐ STIES
- ☐ SWELLING OF LIDS
- ☐ TUNNEL VISION
- ☐ TWITCHING LIDS
- ☐ WATERING
- ☐ OTHER _____

_____

ARE THESE PROBLEMS PRESENT ALL YEAR?
(CIRCLE ONE) YES NO

IF NOT, WHICH SEASON ARE THEY MOST PRESENT?

- ☐ SUMMER
- ☐ FALL
- ☐ WINTER
- ☐ SPRING

EARS

- ☐ CRUSTING INSIDE
- ☐ DIZZINESS
- ☐ DRAINAGE
- ☐ EUSTACHIAN BLOCK
- ☐ EVER LANCED
- ☐ FLOATING SENSATION
- ☐ FLUID ACCUMULATION
- ☐ FREQUENT INFECTIONS
- ☐ HEARING AID
- ☐ HEARING LOSS
- ☐ ITCHING INSIDE
- ☐ ITCHING OUTSIDE
- ☐ LOSS OF BALANCE
- ☐ NERVE DEAFNESS

EARS (CONTINUED)

- ☐ PRESSURE
- ☐ RINGING
- ☐ PAIN
- ☐ ROARING
- ☐ TUBES IN EAR
- ☐ OTHER _____

_____

ARE THESE PROBLEMS PRESENT ALL YEAR? (CIRCLE ONE) YES NO

IF NOT, IN WHICH SEASON ARE THEY MOST PRESENT?

- ☐ SUMMER
- ☐ FALL
- ☐ WINTER
- ☐ SPRING

NOSE

- ☐ BLEEDING
- ☐ BLISTERS
- ☐ BLOCKAGE
- ☐ BURNING
- ☐ CRUSTING
- ☐ DRIPPING/RUNNING
- ☐ ITCHING
- ☐ MUCUS BLOODY
- ☐ MUCUS YELLOW
- ☐ NO SENSE OF SMELL
- ☐ PAIN
- ☐ POLYPS
- ☐ POST NASAL DRIP
- ☐ REQUIRE NOSE DROPS
- ☐ SENSITIVE TO ODORS
- ☐ SINUS INFECTIONS
- ☐ SNEEZING
- ☐ OTHER _____

_____

ARE THESE PROBLEMS PRESENT ALL YEAR?
(CIRCLE ONE) YES NO
IF NOT, IN WHICH SEASON ARE THEY MOST PRESENT?

- ☐ SUMMER
- ☐ FALL
- ☐ WINTER
- ☐ SPRING

MEDICAL HEALTH HISTORY

NOSE (CONTINUED)

MOST COMMON UPON:

☐ ARISING
☐ AFTER MEALS
☐ AFTER MEDICATION
☐ AT NIGHT
☐ COLD WEATHER
☐ DRY WEATHER
☐ HUMID WEATHER
☐ HOT WEATHER
☐ LYING DOWN

MOUTH & THROAT

CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED

☐ BAD BREATH
☐ BAD TASTE
☐ CANKER SORES
☐ CHAPPED LIPS
☐ COATED TONGUE
☐ CRACKS IN TONGUE
☐ DENTURES
☐ DIFFICULTY SWALLOWING
☐ FEVER BLISTERS
☐ GRIND TEETH
☐ GAG EASILY
☐ HOARSE
☐ LIPS CRACK IN CORNERS
☐ LIPS SWELL
☐ METALLIC TASTE
☐ NECK GLANDS SWELL
☐ POSTNASAL DRIP
☐ PURPLISH COLOR TONGUE
☐ SLEEP WITH MOUTH OPEN
☐ SNORING
☐ SORE/RAW TONGUE
☐ SORE THROAT
☐ THROAT CLEARING
☐ THROAT CLOSING
☐ THROAT PALATE ITCHES
☐ TONGUE SWOLLEN
☐ VOICE LOSS
☐ OTHER _____
_____

CARDIAC & RESPIRATORY

'ROUND CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED

☐ ANGINA
☐ ASTHMA
☐ BRONCHITIS
☐ CHEST PAIN

CARDIAC & RESPIRATOR (CONTINUED)

☐ CHEST TIGHTNESS
☐ COUGHING MUCUS
☐ CROUP
☐ DRY COUGH
☐ ENLARGED HEART
☐ FLUSHING
☐ FREQUENT COLDS
☐ FREQUENT COUGHS
☐ FREQUENT INFECTIONS
☐ HEART ATTACK
☐ HEAVINESS IN CHEST
☐ LEG CRAMPS
☐ MURMUR
☐ NIGHT SWEATS
☐ PNEUMONIA
☐ RAPID HEART
☐ SHORTNESS OF BREATH
☐ SKIPPED BEATS
☐ STROKE
☐ SWOLLEN ANKLES
☐ TINGLING
☐ WHEEZING
☐ OTHER _____
_____

HOW FAR CAN YOU WALK VIGOROUSLY BEFORE BECOMING SHORT OF BREATH? _____
_____

HOW FAR CAN YOU WALK VIGOROUSLY BEFORE LEG CRAMPS DEVELOP? _____

WHAT IS YOUR MAIN CARDIAC & RESPIRATORY PROBLEM?_____

WHEN IS IT WORSE?

☐ AFTERNOON
☐ BEFORE LUNCH
☐ FALL
☐ MORNING
☐ NIGHT
☐ SPRING
☐ SUMMER
☐ WINTER
☐ YEAR

LIST CURRENT HEART MEDICATIONS:
_____
_____

MEDICAL HEALTH HISTORY

GASTROINTESTINAL

CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED

- ☐ ANAL ITCHING
- ☐ ANAL PAIN
- ☐ BELCH FREQUENTLY
- ☐ BLOATING
- ☐ BLOODY STOOL
- ☐ CONSTIPATED
- ☐ CRAMPING
- ☐ CRAVE SWEETS
- ☐ DARK STOOL
- ☐ DIARRHEA
- ☐ FAT INTOLERANCE
- ☐ FRAGMENTED STOOL
- ☐ FREQUENT NAUSEA
- ☐ FREQUENT VOMITING
- ☐ GALLBLADDER TROUBLE
- ☐ GOOD APPETITE
- ☐ HEARTBURN
- ☐ INDIGESTION
- ☐ LARGE BULKY STOOL
- ☐ LIGHT COLORED STOOL
- ☐ MUCUS IN STOOL
- ☐ PICKY EATER
- ☐ POOR APPETITE
- ☐ QUEASY STOMACH
- ☐ RECTAL BLEEDING
- ☐ RETASTE FOOD
- ☐ ROUGHAGE INTOLERANCE
- ☐ STOMACH ACHES
- ☐ STOOL FLOATS
- ☐ STOOL STINKS
- ☐ STRONG STOOL ODOR
- ☐ TARRY STOOL
- ☐ ULCER
- ☐ USE LAXATIVES
- ☐ VOMIT BLOOD

☐ OTHER _____

_____

HOW OFTEN DO YOUR BOWELS MOVE?

_____

_____

MUSCULOSKELETAL

DO YOU HAVE JOINT MUSCLE PAIN?
(CIRCLE ONE) YES NO
HOW SEVERE? _____
JOINT SWELLING? _____
(CIRCLE ONE) YES NO

HAS FLUID BEEN REMOVED?
(CIRCLE ONE) YES NO

WHEN DID PAIN OR SWELLING BEGIN?

_____

IS IT CONSTANT OR DOES IT VARY?

_____

DO YOU HAVE MORNING STIFFNESS?
(CIRCLE ONE) YES NO

HOW LONG DOES IT LAST?

_____

WERE YOU EVER DIAGNOSED WITH ANY OF THE THE FOLLOWING?

- ☐ AUTOIMMUNE DISEASE
- ☐ COLLAGEN
- ☐ LUPUS
- ☐ MULTIPLE SCLEROSIS
- ☐ MUSCULAR DYSTROPHY
- ☐ OSTEOARTHRITIS
- ☐ RHEUMATIC FEVER
- ☐ RHEUMATOID ARTHRITIS
- ☐ VASCULAR DISEASE
- ☐ OTHER _____

_____

CONTACT DERMATITIS

DO YOU HAVE A REACTION TO CONTACT WITH ANY SUBSTANCE?
(CIRCLE ONE) YES NO

WHICH SUBSANCES? _____

_____

PART OF BODY AFFECTED? _____

_____

MEDICAL HEALTH HISTORY

CONTACT DERMATITIS (CONTINUED)

WHAT TREATMENT HAS BEEN USED?

_____

_____

_____

CHECK IF YOU HAVE EVER HAD:

☐ POISON IVY
☐ POISON OAK
☐ POISON SUMAC
☐ OTHER _____

_____

DOES CONTACT WITH METAL ON YOUR SKIN CAUSE BREAKING OUT?
(CIRCLE ONE) YES NO

SKIN & HAIR

CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED

☐ ADULT ACNE
☐ ATHLETES FOOT
☐ BLANCHING
☐ BOILS
☐ BRITTLE NAILS
☐ BRUISE EASILY
☐ BURNING FEET
☐ CRACKING
☐ CUTS HEAL SLOWLY
☐ DRYNESS
☐ DULL HAIR
☐ DANDRUFF
☐ ECZEMA
☐ EXCESS HAIR LOSS
☐ FLUSH EASILY
☐ FOOT ODORS
☐ FUNGUS/NAILS
☐ FUNGUS/SKIN
☐ GENITAL HERPES
☐ GOOSEFLESH COMMON
☐ HERPES SIMPLEX
☐ HIVES
☐ ITCHING
☐ LUMPS
☐ NODES
☐ OILINESS
☐ PEELING
☐ RASH
☐ REDNESS
☐ RIDGED NAILS

SKIN & HAIR (CONTINUED)

☐ RINGWORM
☐ SCALY LESIONS
☐ SHINGLES
☐ SORES
☐ SWEATY PALMS
☐ TEENAGE ACNE
☐ WHITE SPOTS ON NAILS
☐ OTHER _____

_____

LIST MAIN AREAS INVOLVED _____

_____

_____

_____

IS YOUR SKIN SENSITIVE TO:

☐ THE SUN
☐ FABRICS
☐ DETERGENTS
☐ OTHER

_____

WHERE? _____

_____

_____

FREQUENCY? _____

_____

_____

INSECT SENSITIVITY

LIST ANY INSECTS THAT CAUSE A MORE SEVERE REACTION THAN NORMAL _____

_____

_____

_____

CHECK ANY REACTIONS YOU MAY HAVE TO INSECT STINGS OR BITES

☐ ANAPHYLAXIS
☐ DIFFICULTY BREATHING
☐ DIFFICULTY SWALLOWING
☐ DIZZINESS
☐ FAINTING
☐ HIVES
☐ LOCAL SWELLING
☐ LOSS OF CONSCIOUSNESS

MEDICAL HEALTH HISTORY

INSECT SENSITIVITY (CONTINUED)

☐ MENTAL CONFUSION
☐ NAUSEA
☐ SHOCK
☐ VOMITING
☐ OTHER _____
_____

DID IT REQUIRE HOSPITALIZATION?
(CIRCLE ONE) YES NO

DO INSECTS SEEM TO SINGLE YOU OUT?
(CIRCLE ONE) YES NO

WHICH INSECTS?
_____
_____
_____

HOW MANY REACTIONS HAVE YOU HAD? _____
_____

WHAT TYPE OF TREATMENT DO YOU RECEIVE AFTER EACH REACTION? _____
_____

URINARY & GENITALIA

CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED CONSTANT

☐ BEDWETTING
☐ BLADDER DISEASE
☐ BLADDER INFECTION
☐ BURNING
☐ CANCER *
☐ CYSTITIS
☐ DIFFICULTY URINATING
☐ DISCHARGE
☐ FREQUENT URINATION
☐ FRIGIDITY
☐ GENITAL HERPES
☐ IMPOTENCE
☐ ITCHING
☐ KIDNEY DISEASE
☐ KIDNEY INFECTION
☐ KIDNEY STONES
☐ LACK OF CONTROL
☐ PAINFUL URINATION

URINARY & GENITALIA (CONTINUED)

☐ PASS BLOOD
☐ PROSTATE TROUBLE
☐ SORES
☐ SPOUSE TREATED FOR TRICHOMONAS
☐ TREATED FOR INFECTION
☐ TREATED FOR YEAST INFECTION
☐ TRICHOMONAS (SELF)
☐ TRICHOMONAS TREATED
☐ YEAST INFECTION

☐ OTHER _____
_____

* LOCATION OF CANCER _____
_____
_____
YEAR DIAGNOSED/TREATED _____

HEADACHE & CEREBRAL

CHECK ANY OF THE FOLLOWING TYPES OF HEADACHE PAIN YOU HAVE EXPERIENCED:

☐ ACUTE
☐ BAND-LIKE
☐ BORING
☐ BURNING
☐ CAP-LIKE
☐

☐ CONSTRICTION
☐ CRAMP-LIKE
☐ CUTTING
☐ DRAWING
☐ DULL
☐ EPISODIC
☐ EXCRUCIATING
☐ HEAVINESS
☐ PRESSURE
☐ PULSATING
☐ SHARP
☐ SORENESS
☐ THROBBING
☐ TIGHT
☐ VISE-LIKE
☐ OTHER _____
_____
_____
_____

HEALTH HISTORY

HEADACHE & CEREBRAL (CONTINUED)

CHECK LOCATION OF PAIN

☐ BACK OF EYE
☐ BACK OF HEAD
☐ BACK OF NECK
☐ CHEEK
☐ CROWN
☐ FOREHEAD
☐ LEFT SIDE OF HEAD
☐ RIGHT SIDE OF HEAD
☐ TOP OF HEAD
☐ UPPER TEETH

☐ OTHER _____
_____

CHECK ANY OF THE FOLLOWING THAT ARE ASSOCIATED WITH THE HEADACHE

☐ ABDOMINAL PAIN
☐ BEGINS SLOWLY
☐ BEGINS SUDDENLY
☐ CHILLY SENSATION
☐ CLEARS COMPLETELY
☐ CLEARS WITH TREATMENT
☐ DAZZLING LIGHTS
☐ DIARRHEA
☐ EPISODIC
☐ FLUSHING
☐ INFLAMED EYE
☐ LASTS FOR DAYS
☐ LASTS HOURS
☐ LASTS SECONDS
☐ LOSS OF SIGHT
☐ NASAL BLOCKAGE
☐ NAUSEA
☐ NECK/SHOULDER PAIN
☐ PALLOR
☐ QUEASY STOMACH
☐ RELIEVED BY WALKING
☐ RETURNS REGULARLY
☐ RUNNING NOSE
☐ SWELLING OF EYE
☐ TEARING
☐ VISUAL DISTURBANCE
☐ VOMITING
☐ WORSE LYING DOWN
☐ OTHER _____
_____

CHECK ANY OF THE FOLLOWING THAT PROCEED OR INTENSIFY PAIN

☐ ALCOHOL
☐ ANGER
☐ ANXIETY
☐ ARGUMENTS
☐ CHILLING
☐ COFFEE/TEA
☐ DISAPPOINTMENT
☐ EXERCISE
☐ EYE STRAIN
☐ INFECTIONS
☐ FASTING
☐ FOODS
☐ HUMIDITY
☐ INTENSE LIGHT
☐ MOTION
☐ MUSCLE STRAIN
☐ NOISE
☐ ODORS
☐ OVERHEATING
☐ REJECTION
☐ UNUSUAL STIMULATION
☐ OTHER _____
_____

CHECK WHEN YOU HEADACHE USUALLY OCCURS

☐ AFTER BREAKFAST
☐ AFTER LUNCH
☐ AFTER SUPPER
☐ BEFORE BREAKFAST
☐ BEFORE LUNCH
☐ BEFORE PERIOD
☐ BEFORE SUPPER
☐ DURING
☐ MENSTRUATION
☐ DURING SLEEP
☐ ON ARISING
☐ WHEN LYING DOWN
☐ SUMMER
☐ FALL
☐ WINTER
☐ SPRING

☐ OTHER _____
_____
_____

AT WHAT AGE DID HEADACHES BEGIN? _____

HEALTH HISTORY

HEADACHE & CEREBRAL (CONTINUED)

CHECK ANY OF THE FOLLOWING THAT APPLY WHEN YOU HAVE A HEADACHE:

- ☐ APPLY HOT/COLD COMPRESS
- ☐ APPLY PRESSURE TO HEAD
- ☐ CAN KEEP WORKING
- ☐ CANNOT KEEP WORKING
- ☐ REQUIRE BED REST
- ☐ REQUIRE DARKNESS
- ☐ REQUIRE EYE COVERING
- ☐ REQUIRE HOSPITALIZATION

☐ OTHER _____

_____

CHECK IF YOU HAVE EVER EXPERIENCED ANY OF THE FOLLOWING:

- ☐ BACK /NECK INJURY
- ☐ BEEN KNOCKED UNCONSCIOUS
- ☐ DENTAL OCCLUSION
- ☐ ENCEPHALITIS
- ☐ HEAD INJURY
- ☐ REGULAR DENTAL CARE
- ☐ SKULL FRACTURE

☐ OTHER _____

_____

CHECK ANY OF THE FOLLOWING FOUND IN YOUR FAMILY:

- ☐ BRAIN TUMORS
- ☐ CHEMICAL ALLERGIES
- ☐ EMOTIONAL PROBLEMS
- ☐ FOOD ALLERGIES
- ☐ HEADACHES
- ☐ INHALANT ALLERGIES
- ☐ NERVOUS BREAKDOWN
- ☐ UNDUE FATIGUE

DO YOU HAVE ANY CAUSES FOR HEADACHES?
(CIRCLE ONE) YES NO

IF YES, EXPLAIN_____

_____

_____

_____

_____

_____

_____

HAVE YOU BEEN HOSPITALIZED FOR A HEADACHE?
(CIRCLE ONE) YES NO

IF YES, WHEN? _____

WHAT TREATMENT HAVE YOU RECEIVED FOR HEADACHES? _____

LIST MEDICATIONS YOU TAKE FOR YOUR HEADACHE: _____

_____

_____

PSYCHOLOGICAL HISTORY

CHECK THOSE THAT APPLY

- ☐ AGGRESSIVENESS
- ☐ ALCOHOL ABUSE
- ☐ AMNESIA
- ☐ ANXIETY
- ☐ BLACKOUTS
- ☐ CLUMSINESS
- ☐ COLD SWEATS
- ☐ CONCENTRATION
- ☐ CONSIDERED NERVOUS
- ☐ CONTROLLED BY OTHER FORCES
- ☐ CONVULSIONS
- ☐ CRY OFTEN
- ☐ DAYTIME SLEEPINESS
- ☐ DEPRESSION
- ☐ DIFFICULTY FALLING ASLEEP
- ☐ DIFFICULTY STAYING AWAKE
- ☐ DIZZINESS
- ☐ DRUG ADDICTION
- ☐ EASILY ANGERED
- ☐ EXTREMELY SHY/SENSITIVE
- ☐ FAINTING
- ☐ FAMILY MEMBER/NERVOUS BREAKDOWN
- ☐ FEELING OF HOSTILITY
- ☐ FEEL LOST MOST OF THE TIME
- ☐ FORGETFUL
- ☐ FREQUENTLY KEYED UP/JITTERY
- ☐ FRUSTRATION
- ☐ GO TO PIECES EASILY
- ☐ GROGGINESS
- ☐ HAD NERVOUS BREAKDOWN
- ☐ HEARD VOICES
- ☐ HOSPITALIZED FOR NERVES
- ☐ INCESSANT TALKER
- ☐ INNER TREMBLING
- ☐ INSECURITY

HEALTH HISTORY

PSYCHOLOGICAL HISTORY (CONTINUED)

- ☐ INSECURITY
- ☐ IRRITABILITY
- ☐ LISTLESSNESS
- ☐ MISUNDERSTOOD BY OTHERS
- ☐ NUMBNESS
- ☐ OFTEN FEEL SUDDENLY SCARED
- ☐ OFTEN UNABLE TO WORK
- ☐ OFTEN UNHAPPY
- ☐ PALE COMPLEXION
- ☐ PERFECTIONIST
- ☐ POOR MUSCLE CONDITION
- ☐ PROFUSE SWEATING
- ☐ RESTLESS LEGS
- ☐ SHAKINESS
- ☐ SHOCK THERAPY
- ☐ SHORT ATTENTION SPAN
- ☐ SLEEP WALKING
- ☐ STARTLED BY NOISES
- ☐ STUPOROUS
- ☐ UNABLE TO CONCENTRATE
- ☐ UNABLE TO REASON
- ☐ UNDUE FATIGUE
- ☐ UNUSUAL TENSION
- ☐ USE TRANQUILIZERS
- ☐ VISION CHANGES
- ☐ WITHDRAWN FEELING
- ☐ WORRIED BY LITTLE THINGS
- ☐ WORKAHOLIC

☐ OTHER _____

_____

CHILDHOOD

AS AN INFANT, DID YOU HAVE ANY OF THE FOLLOWING:

- ☐ BEDWETTING
- ☐ CAR SICKNESS
- ☐ CLUMSY/UNCOORDINATED
- ☐ DISCIPLINE PROBLEM
- ☐ DYSLEXIA
- ☐ FINICKY APPETITE
- ☐ HAD FEW FRIENDS
- ☐ HEAD & NECK PAIN
- ☐ HEADACHES
- ☐ HYPERACTIVITY/ATTENTION DEFICIT DISORDER
- ☐ INTENSE TEMPER/FURY
- ☐ MARKEDLY SHY/TIMID
- ☐ READING PROBLEMS
- ☐ SLOW TO LEARN

CHILDHOOD (CONTINUED)

- ☐ SWEATS/SLEEPING
- ☐ TROUBLE SLEEPING
- ☐ UNABLE TO GAIN WEIGHT
- ☐ USUALLY MEDDLESOME
- ☐ WHINY/BAD TEMPERED
- ☐ WRITING PROBLEMS
- ☐ OTHER _____

_____

AS AN INFANT, DID YOU HAVE ANY OF THE THE FOLLOWING:

- ☐ BEHAVIOR PROBLEMS
- ☐ BOTTLE FED
- ☐ COLIC
- ☐ CONSTANT HUNGER
- ☐ CONSTANT CONSTIPATION
- ☐ DIARRHEA
- ☐ EAR INFECTION
- ☐ ECZEMA
- ☐ FAILURE TO THRIVE
- ☐ FUSSINESS
- ☐ GASSINESS
- ☐ HYPERACTIVITY
- ☐ LEARNING PROBLEMS
- ☐ LEG ACHES
- ☐ NIGHT SWEATS
- ☐ PICKY EATER
- ☐ POOR APPETITE
- ☐ RECURRENT INFECTION
- ☐ SKIN RASH
- ☐ STOMACH ACHES
- ☐ VOMITING

WOMEN ONLY

CHECK IF YOU HAVE EVER EXPERIENCED ANY OF THE FOLLOWING:

- ☐ BREAST BIOPSY
- ☐ BREAST CYSTS OR LUMPS
- ☐ BREAST SORENESS DURING PERIOD
- ☐ BREAST SORENESS NRELATED TO PERIOD
- ☐ MASTECTOMY
- ☐ EXCESSIVE HAIR GROWTH (FACE, BREASTS)
- ☐ PROBLEMS WITH INFANTS _____

_____

_____

_____

_____

HEALTH HISTORY

WOMEN ONLY (CONTINUED)

NUMBER OF CHILDREN_____

NORMAL BIRTHS _____

NORMAL PREGNANCY?
(CIRCLE ONE) YES NO

IF NOT, EXPLAIN _____
_____
_____
_____

DIFFICULT LABOR?
(CIRCLE ONE) YES NO

IF YES, EXPLAIN_____
_____
_____

WHAT TREATMENT DID YOU RECEIVE? _____
_____
_____

BIRTHWEIGHTS:
_____ _____ _____ _____ _____ _____ _____

NUMBER OF MISCARRIAGES _____

REASON(S)_____
_____
_____

MENSES

- ☐ AGE AT ONSET_____
- ☐ HAD D&C
- ☐ HEAVY FLOW
- ☐ HYSTERECTOMY
- ☐ IRREGULAR PERIODS
- ☐ MISCARRIAGE
- ☐ NOW PREGNANT
- ☐ PARTIAL HYSTERECTOMY
- ☐ PMS
- ☐ REGULAR PERIODS
- ☐ SCANT FLOW
- ☐ TRYING TO GET PREGNANT
- ☐ USE BIRTH CONTROL PILLS
- ☐ USE DIAPHRAGM
- ☐ USE DOUCHES

MENSES (CONTINUED)

- ☐ USE FOAM
- ☐ USE IUD
- ☐ USE LUBRICANTS

- ☐ OTHER

(INCLUDE FEMALE SURGERIES)_____
_____

WHAT PROBLEMS DO YOU HAVE BEFORE PERIODS? _____
_____

DURATION _____

WHAT PROBLEMS DO YOU HAVE DURING OVULATION? (MIDDLE OF CYCLE) _____
_____
_____

DURATION _____
_____

MENOPAUSE

AGE AT MENOPAUSE _____

TAKING HORMONES? YES NO (CIRCLE ONE)

HOW LONG? _____

ALLERGY TREATMENT

HAVE YOU HAD ALLERGY TESTS?
YES NO (CIRCLE ONE)
WHEN?_____
WHERE? _____
_____
WHAT TYPE? _____
_____
PHYSICIAN'S NAME: _____
_____

ARE YOU TAKING ALLERGY MEDICATIONS OR INJECTIONS NOW? YES NO (CIRCLE ONE)

WHAT TYPE? _____
_____
_____
_____

HEALTH HISTORY

ALLERGY TREATMENT (CONTINUED)

ADRENALINE INJECTIONS FOR
ALLERGIES REQUIRED?
YES NO NUMBER OF TIMES _____

EMERGENCY TREATMENT FOR
ALLERGIES REQUIRED?
YES NO NUMBER OF TIMES _____

INHALANT AND CHEMICAL HISTORY

OCCUPATIONAL INFORMATION

- ☐ TEACHER
- ☐ PROFESSIONAL
- ☐ SALESPERSON
- ☐ PAINTER
- ☐ OFFICE WORKER
- ☐ FACTORY WORKER
- ☐ CONSTRUCTION WORKER
- ☐ FARM WORKER
- ☐ HOUSE WORKER
- ☐ PAINTER
- ☐ HOSPITAL WORKER
- ☐ WORK INDOORS
- ☐ WORK OUTDOORS
- ☐ WORK AROUND DUST
- ☐ WORK WITH ANIMALS
- ☐ WORK WITH COSMETICS
- ☐ WORK IN EXTREME HEAT
- ☐ WORK IN EXTREME COLD
- ☐ WORK AROUND NOXIOUS FUMES

AT WORK, DO YOU FEEL……..

- ☐ BETTER
- ☐ WORSE
- ☐ SAME

INHALANT & CHEMICAL HISTORY

CHECK ANY OF THE FOLLOWING THAT CAUSE IRRITATION

- ☐ ALCOHOL
- ☐ ARTIST SUPPLIES
- ☐ BIRD INSIDE
- ☐ CAT INSIDE
- ☐ CENTRAL HEATING/COOLING
- ☐ CHEMICALS
- ☐ COSMETICS
- ☐ COTTON
- ☐ DEODORANTS
- ☐ DETERGENTS
- ☐ DIESEL FUEL
- ☐ DISINFECTANTS
- ☐ DOG INSIDE
- ☐ DRAPES
- ☐ DUST
- ☐ DYES
- ☐ EXHAUST FUMES
- ☐ EYE MAKEUP
- ☐ FEATHERS
- ☐ FERTILIZERS
- ☐ FIREPLACE
- ☐ FLOOR FURNACE
- ☐ FLOOR WAX
- ☐ FRESH NEWSPAPERS
- ☐ FURNITURE POLISH
- ☐ GASOLINE FUMES
- ☐ GAS STOVE/HEAT
- ☐ GLUE
- ☐ GRAIN DUST
- ☐ HAIRSPRAY
- ☐ HEMP
- ☐ HERBICIDES
- ☐ INCENSE
- ☐ INSECTICIDES
- ☐ KAPOK
- ☐ LACQUERS
- ☐ MARSHY AREAS
- ☐ MILDEW
- ☐ MOLDS
- ☐ MOTHBALLS
- ☐ NAIL POLISH
- ☐ NEW CARPET
- ☐ OLD CARPET
- ☐ NEW HOME
- ☐ OLD HOME
- ☐ NEWSPRINT
- ☐ OLD MAGAZINES
- ☐ OVERSTUFFED FURNITURE
- ☐ PAINTS
- ☐ PERFUMES
- ☐ PHOTOCOPY PAPER
- ☐ PLASTIC
- ☐ POTTED PLANTS
- ☐ RAISED HOME
- ☐ RUBBER
- ☐ RUGS
- ☐ SISAL
- ☐ SLAB HOME
- ☐ SOAPS
- ☐ SOLVENTS
- ☐ SPACE HEATERS
- ☐ TAR
- ☐ TOBACCO SMOKE
- ☐ TURPENTINE
- ☐ VARNISHES
- ☐ WOODED AREAS
- ☐ WOOD SMOKE
- ☐ OTHER _____

HEALTH HISTORY

INHALANT & CHEMICAL HISTORY (CONTINUED)

CHECK IF YOU HAVE HAD REACTIONS IN THE IN THE FOLLOWING CONDITIONS

- ☐ SPRING
- ☐ SUMMER
- ☐ FALL
- ☐ WINTER
- ☐ YEAR LONG
- ☐ WHEN TOO HOT
- ☐ WHEN TOO COLD
- ☐ HUMID WEATHER
- ☐ WINDY WEATHER
- ☐ WORSE AT DAYTIME
- ☐ WORSE AT NIGHT
- ☐ CERTAIN ROOMS
- ☐ IN MOLDY PLACES
- ☐ SPECIFIC ODORS
- ☐ FROM DYES
- ☐ HOUSE CLEANING
- ☐ PHYSICAL EXERTION
- ☐ WHEN CUTTING GRASS
- ☐ RAKING LEAVES
- ☐ OTHER _____

_____

LIST FAMILY HOBBIES

_____

_____

_____

NOTE NAME BRANDS OF ANY PRODUCTS YOU USE REGULARLY

AFTER SHAVE _____
BREATH FRESHENERS _____
CHAPSTICK _____
CHEWING GUM _____
COUGH DROPS _____
DENTAL ADHESIVE _____
DENTIFRICE _____
FABRIC SOFTENER _____
LAUNDRY DETERGENT _____
LIPSTICK _____
MOUTHWASH _____
PERFUME _____
TOOTHPASTE _____
OTHER _____

ENVIRONMENT

DO YOULIVE IN AN APARTMENT?
(CIRCLE ONE) YES NO

AGE OF APARTMENT _____

DO YOU LIVE IN A HOUSE?
(CIRCLE ONE) YES NO

AGE OF HOUSE _____

DOES YOUR HOUSE TEND TO GET DUSTIER THAN OTHER HOMES?
(CIRCLE ONE) YES NO

HEATING SYSTEM

- ☐ ELECTRIC BASEBOARD
- ☐ ELECTRIC PANEL
- ☐ FIREPLACE
- ☐ FLOOR FURNACE
- ☐ GAS FURNACE
- ☐ HOT WATER HEATER
- ☐ OIL FURNACE
- ☐ RADIATOR STEAM HEAT
- ☐ SPACE HEATER
- ☐ WALL FURNACE
- ☐ WOOD STOVE
- ☐ OTHER _____

_____

PILLOWS

- ☐ DOWN
- ☐ FEATHER
- ☐ FOAM RUBBER
- ☐ KAPOK
- ☐ SYNTHETIC
- ☐ OTHER _____

_____

ROOMMATE'S PILLOW

- ☐ DOWN
- ☐ FEATHER
- ☐ FOAM RUBBER
- ☐ KAPOK
- ☐ SYNTHETIC
- ☐ OTHER _____

_____

HEALTH HISTORY

MATTRESS

☐ BOX SPRING
☐ FOAM RUBBER
☐ FUTON
☐ INNER SPRING
☐ WATERBED
☐ OTHER _____

BLANKETS

☐ COTTON
☐ QUILT
☐ SYNTHETIC
☐ WOOL
☐ OTHER_____

ANIMALS & PETS

☐ BIRD
☐ CAT
☐ DOG
☐ GUINEA PIG
☐ HAMSTER
☐ HORSE
☐ RABBIT
☐ OTHER _____

PLANTS

☐ HAVE IND OOR
☐ FLOWERING

HOW MANY? _____

DRUG/MEDICATION HISTORY

☐ ACETAMINOPHEN
☐ ADRENALIN
☐ ANTACIDS
☐ ANTIBIOTICS
☐ ANTIHISTAMINES
☐ ASPIRIN
☐ BIRTH CONTROL PILLS
☐ BLOOD PRESSURE MEDICINE
☐ CODEINE
☐ CORTISONE
☐ COUGH MEDICINE
☐ DEMEROL
☐ DIGITALIS
☐ DILANTIN
☐ HORMONES
☐ INSULIN
☐ LAXATIVES
☐ NOSE DROPS
☐ PAREGORIC
☐ PHENOBARBITOL
☐ SLEEPING PILLS
☐ SULFA DRUGS
☐ TRANQUILIZERS
☐ OTHER _____
_____

LIST ANY OTHER DRUGS OR MEDICATIONS OR ANTIBIOTICS THAT CAUSE A REACTION: _____
_____

HAVE YOU REACTED TO:

☐ DENTAL ANESTHETICS
☐ IODIDES
☐ TETANUS ANTITOXINS
☐ TETANUS TOXOID
☐ X-RAY CONTRAST MEDIA

DO YOU REQUIRE ADJUSTED DOSES OF MEDICATIONS? (CIRCLE ONE) YES NO

SUPPLEMENT HISTORY

☐ ELECTROLYTES
☐ IRON
☐ MINERALS
☐ VITAMINS
☐ OTHER _____
_____

LIST SUPPLEMENTS YOU TAKE REGULARLY OR OCCASIONALLY: _____
_____
_____

HEALTH HISTORY

FOOD HISTORY

WHICH OF THE FOLLOWING HAVE YOU EXPERIENCED?

- ☐ AVOID CERTAIN FOODS
- ☐ BOTHERED BY FOOD ODOR
- ☐ CAVEMAN DIETS
- ☐ COOK FROM SCRATCH
- ☐ CRAVE BEVERAGES
- ☐ CRAVE CERTAIN FOODS
- ☐ DISLIKE CERTAIN FOODS
- ☐ EAT DAYTIME SNACKS
- ☐ EAT JUNK FOODS
- ☐ EAT REGULAR MEALS
- ☐ ELIMINATION DIETS
- ☐ EXCESSIVE HUNGER
- ☐ EXCESSIVE THIRST
- ☐ HAVE BEDTIME SNACKS
- ☐ ROTATION DIETS
- ☐ SKIP MEALS ON REGULAR BASIS
- ☐ USE CONVENVIENCE FOODS
- ☐ USE EXOTIC FOODS
- ☐ WEIGHT GAIN
- ☐ WEIGHT LOSS

☐ OTHER _____

_____

HAVE YOU EVEN BEEN ON A SPECIAL DIET? YES NO

WHAT KIND? _____

WHAT KIND OF FOODS DO YOU CRAVE? _____

WHAT KIND OF FOODS DO YOU DISLIKE?

DO YOU EAT FOODS THAT ARE

- ☐ CANNED
- ☐ FRESH
- ☐ FROZEN
- ☐ PREPACKAGED

DO YOU EAT MOST OF YOUR MEALS:

- ☐ HOME
- ☐ RESTAURANTS

WHAT HAPPENS IF YOU MISS A MEAL?

_____

IS THERE A FAMILY HISTORY OF ALLERGIES OR FOOD INTOLERANCE?

YES NO

IF YES, EXPLAIN_____

HEALTH HISTORY

FOOD LIST

OF THE FOLLOWING LIST OF FOODS, PLEASE CHOOSE THE LETTER THAT BEST REPRESENTS YOUR EATING HABITS

A = EAT DAILY	E = CRAVE/REALLY LIKE
B = EAT A FEW TIMES A WEEK	F = DO NOLIKE
C = EAT SELDOM	G = LIKE,BUT BOTHERS ME
D = NEVER EAT	H = LIKE,BUT AVOID OR LIMIT

_____ALLSPICE	_____BLUEBERRY	_____CHICKEN
_____ALMOND	_____RASPBERRY	_____CHICORY
_____APPLE	_____BLACK-EYES PEAS	_____CHILI PEPPER
_____APRICOT	_____BRAZIL NUT	_____CHILI POWDER
_____ARROWROOT	_____BROCCOLI	_____CHOCOLATE
_____ARTICHOKE	_____BRUSSEL SPROUTS	_____COCOA
_____ASPARAGUS	_____BUCKWHEAT	_____CINNAMON
_____AVOCADO	_____CABBAGE	_____CLOVE
_____BANANA	_____CAKE	_____COCONUT
_____BARLEY	_____CANDY	_____COCONUT OIL
_____BASIL	_____CARAWAY	_____COFFEE
_____BAY LEAF	_____CAROB	_____COLA
_____KIDNEY BEAN	_____CARROT	_____COOKIES
_____LIMA BEAN	_____CASHEW	_____CORN CHIPS
_____NAVY BEAN	_____CATSUP	_____COTTAGE CHEESE
_____PINTO BEAN	_____CAULIFLOWER	_____CRANBERRY
_____BEEF	_____CELERY	_____CUCUMBER
_____BEETS	_____CHEDDAR CHEESE	_____CURRY
_____BELL PEPPER	_____CHERRY	_____DATES
_____BLACKBERRY	_____CHEWING GUM	_____DILL

HEALTH HISTORY

_____ DUCK

_____EGG

_____EGGPLANT

_____ENDIVE

_____FIG

_____GARLIC

_____GELATIN

_____GINGER

_____GRAPEFRUIT

_____GRAPES

_____HAZELNUT

_____HONEY

_____HOPS

_____HORSERADISH

_____ICE CREAM

_____JAM/JELLY

_____LAMB

_____LEMON

_____LENTIL

_____LETTUCE

_____LICORICE

_____LIME

_____MANGO

_____MAPLE SYRUP

_____MAYONNAISE

_____CANTALOUPE

_____CASABA MELON

_____HONEYDEW MELON

_____PERSIAN MELON

_____WATERMELON

_____MILK (COW)

_____MILK (GOAT)

_____MOLASSES

_____MUNG BEAN

_____MUSHROOMS

_____MUSTARD

_____MUSTARD GREENS

_____NUTMEG

_____OATS

_____OKRA

_____OLIVE

_____OLIVE OIL

_____ONION

_____ORANGE

_____POTATO CHIPS

_____OREGANO

_____PAPAYA

_____PAPRIKA

_____PARMESAN CHEESE

_____PARSLEY

_____PARSNIP

_____PEAS

_____PEACH

_____PEANUT

_____PEANUT OIL

_____PEAR

_____PECAN

_____PEPPER

_____PEPPERMINT

_____PIE/CREAM

_____PIE/FRUIT

_____PIMENTO

_____PINEAPPLE

_____PISTACHIO

_____PLUM

_____POPPY SEED

_____PORK

_____POTATO (SWEET)

_____POTATO (WHITE)

_____PROCESSED FOODS

_____PRUNE

_____PUMPKIN SEED

_____RAISIN

_____RABBIT

_____RADISH

_____RICE

_____ROQUEFORT

_____RYE

_____SACCHARIN

_____SAFFLOWER OIL

_____SAGE

HEALTH HISTORY

____SALT
____SESAME SEED OIL
____SOY
____SPEARMINT
____SPINACH
____SQUASH
____STRAWBERRY
____STRING BEAN
____SUGAR BEET
____SUGAR CANE
____SUNFLOWER SEEDS
____TANGERINE
____TAPIOCA
____TEA
____THYME
____TOMATO
____TURKEY
____TURNIP
____V8 JUICE
____VANILLA
____VENISON
____VINEGAR
____WALNUT
____WHEAT
____YEAST
____YOGURT

FISH/SEA FOOD

____BASS
____CATFISH
____CLAM
____COD
____CRAB
_____ FLOUNDER
____HALIBUT
____HADDOCK
____HERRING
____LOBSTER
____MACKEREL
____OYSTER
____PERCH
____RED SNAPPER
____SALMON
____SARDINE
____SCALLOP
____SHRIMP
____SOLE
____STURGEON
____TROUT
____TUNA

OTHER FOODS: _____

HEALTH HISTORY

EATING PATTERN

PLEASE LIST THE FOODS YOU NORMALLY CONSUME ON A TYPICAL DAY.
INCLUDE SNACKS, BEVERAGES, ETC.

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

SUPPLEMENTS TAKEN:

OTHER: