



# Functional Health Patient History

Date : \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Sex: M F DOB \_\_\_\_\_ Marital Status: M D S W  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Present Complaints

1. Main Problem(s): \_\_\_\_\_  
\_\_\_\_\_
2. In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own words and your own opinion what do you think the real problem is : \_\_\_\_\_  
\_\_\_\_\_

## Diagnosis

### Diabetes

Have you been diagnosed with Type II diabetes: Y N  
Are you Insulin Dependent? Y N  
When were you diagnosed with Type II diabetes: \_\_\_\_\_  
What diagnostic tools were used to achieve your diagnosis:  
\_\_\_\_\_

### Blood Sugar

HIGHEST your blood sugar gets WITHOUT medication: \_\_\_\_\_  
HIGHEST your blood sugar gets WITH medication: \_\_\_\_\_  
LOWEST your blood sugar gets WITHOUT medication: \_\_\_\_\_  
LOWEST your blood sugar gets WITH medication: \_\_\_\_\_

### Thyroid

Have you:  
Thought you had a thyroid problem, but not had a diagnosis: Y N  
Been tested for and auto-immune (Hashimoto's) thyroid condition: Y N  
Been diagnosed with an auto-immune thyroid condition: Y N  
Are you currently taking thyroid hormones: Y N  
What symptoms persisted AFTER taking thyroid hormones:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. What are the three things your condition has caused you to miss most:  
\_\_\_\_\_  
\_\_\_\_\_
4. How often are you aware of your main problem (circle one):  
Occasionally (25% of the time) Intermittently (50% of the time)  
Frequently (75% of the time) Constantly (100% of the time)
5. Symptoms(list all):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Severity (circle):  
Minimal (annoying but causing no limitation)  
Slight (tolerable but causing a little limitation)  
Moderate (sometimes tolerable but definitely causing limitation)  
Severe (causing significant limitation)  
Extreme (causing near constant limitation (>80% of the time))
7. What relieves your symptoms or causes them to return:  
\_\_\_\_\_  
\_\_\_\_\_
8. Describe the first time you remember having symptoms:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Do your symptoms occur at a specific time, place, or environment: Y N

When and for how long do symptoms last each episode:

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11. What are you hoping happens today as a result of your consultation:

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13. If you cannot find a solution to your problem what do you think will happen?

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10. List your health goals in order of Importance:

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Motivation to achieve these goals: 1 2 3 4 5 6 7 8 9 10

12. Due to your condition have you lost time from?

Work: Y N Describe:

Family: Y N Describe:

Leisure Activities Y N Describe:

### Medications and Therapy

#### PRIOR MEDICATIONS:

(Rx, OTC, botanicals, homeopathic, supplements)

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#### CURRENT MEDICATIONS:

(Rx, OTC, botanicals, homeopathic, supplements)

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#### PRIOR NUTRITIONAL THERAPY:

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#### CURRENT NUTRITIONAL THERAPY:

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#### PRIOR ALTERNATIVE/HOLISTIC THERAPY:

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#### CURRENT ALTERNATIVE/HOLISTIC THERAPY:

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### Medical and Social History

#### Surgeries/Hospitalizations

Date

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#### Trauma

Date

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#### Past/Recent Illness

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#### Family History of Disease (mother, father, siblings, spouse, children)

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#### Social History

Do you use: Alcohol Y N Tobacco Y N Caffeine Y N

\_\_\_ drinks/week

\_\_\_ pack/day

\_\_\_ cups/day

## Review of Systems: Past and Current

(Have you ever had the following (circle "P" for past and "C" for current - leave blank if you do not or have not experienced))

### CONSTITUTIONAL

- P C Fatigue
- P C Recent weight change
- P C Fever

### EYES

- P C Blurred/double vision
- P C Glasses/contacts
- P C Eye disease or injury

### EAR/NOSE/MOUTH/THROAT

- P C Swollen glands in neck
- P C Hearing loss or ringing
- P C Earaches or drainage
- P C Chronic sinus problems or rhinitis
- P C Nose bleeds
- P C Mouth sores / Bleeding gums
- P C Bad breath / bad taste
- P C Sore throat or voice change

### CARDIOVASCULAR

- P C High or Low Blood Pressure
- P C Shortness of breath walking/lying
- P C Heart disease
- P C Chest pain or angina pectoris
- P C Palpitation
- P C Mitral Valve Prolapse
- P C Feet or ankle swelling
- P C Shortness of breath
- P C Spitting up blood

### PSYCHIATRIC

- P C Insomnia
- P C Memory loss or confusion
- P C Nervousness
- P C Depression

### GENITOURINARY

- P C Frequent urination
- P C Burning or painful urination
- P C Blood in urine
- P C Change in force or strain urinating
- P C Kidney stones
- P C Sexual difficulty
- P C Male : testicle pain
- P C Female: pain / irregular periods
- P C Female: pregnant
- P C Bladder Infections
- P C Kidney Disease
- P C Hemorrhoids

### GASTROINTESTINAL

- P C Abdominal pain
- P C Nausea or Vomiting
- P C Rectal bleeding/blood in stool
- P C Painful bm / constipation
- P C Ulcer
- P C Change in bowel movement
- P C Frequent diarrhea
- P C Loss of appetite

### RESPIRATORY

- P C Chronic or frequent cough
- P C Spitting up blood
- P C Pneumonia / Bronchitis
- P C Shortness of breath
- P C Wheezing
- P C Asthma

### ENDOCRINE

- P C Glandular or hormone problem
- P C Excessive thirst or urination
- P C Heat or cold intolerance
- P C Skin becoming dryer
- P C Change in hat or glove size
- P C Diabetes
- P C Thyroid Disease

### MUSCULOSKELETAL

- P C Back pain
- P C Joint pain
- P C Joint stiffness and swelling
- P C Muscle pain or cramps
- P C Muscle or joint weakness
- P C Difficulty walking
- P C Cold extremities

### INTEGUMENTARY (skin, breast)

- P C Change in skin color
- P C Change in Hair or Nails
- P C Varicose veins
- P C Breast pain / discharge
- P C Breast lump
- P C Hives or Eczema
- P C Rash or itching

ALLERGIES / OTHER (drugs, food, or environmental) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

RECENT TESTS (lab work, x-rays, CT, MRI) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### NEUROLOGICAL

- P C Freq./ recurring headaches
- P C Migraine headache
- P C Convulsions or seizures
- P C Numbness or tingling
- P C Tremors
- P C Paralysis
- P C Head injury
- P C Light headed or dizzy
- P C Stroke

### HEMATOLOGIC/LYMPHATIC/OTHER

- P C Slow to heal after cuts
- P C Easy bleeding or bruising
- P C Anemia
- P C Phlebitis
- P C Past transfusion
- P C Enlarged glands
- P C Blood or Plasma Transfusions
- P C Hepatitis
- P C Cancer
- P C Infectious Mono
- P C AIDS or HIV+
- P C Venereal
- P C Chicken pox