

# *White Lotus Health Center*

## Health History Form

Name:		
Address:	City:	State:
Zip:	Phone:(h):	(b):
Sex:	Age:	Date of Birth:
Occupation:	Birthplace:	
Do you like your job?	Retired?	When?
How many weeks of holiday do you take per year?		
Past occupations:		
Marital status:	No. of children:	
Religion or personal philosophy:		
Family physician:	Phone:	
Referred by:		

What are your main health concerns? (List in order of importance, from most important to least)

- ( ) routine check-up: no symptoms Date problem started
1. \_\_\_\_\_ \_\_\_\_\_
  2. \_\_\_\_\_ \_\_\_\_\_
  3. \_\_\_\_\_ \_\_\_\_\_
  4. \_\_\_\_\_ \_\_\_\_\_

### Medical History

#### General:

Date of last physical exam:	Weight:	Height:
Maximum weight:	When?	Energy level (scale 1-10 : 10 highest):
Blood type:	Date of last blood test:	Why?
Do you usually wake up feeling refreshed?	Do you have any problems falling asleep?	
Hours of sleep/night:	Number of times wake up during the night:	
Any dental work done before problems started?	When?	What?
Number of meals per day?	Snacks?	Vegetarian?
Have you ever smoked?	Do you smoke now?	How many cigarettes per day?
Have you ever used recreational drugs? If so, what drugs and how long did you use them?		
Do you drink alcohol? Yes No	How many drinks per week?	
Do you drink coffee? Yes No	Cups per day?	
Do you have any known allergies? Yes No	To what?	
When did the allergies begin?		

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Current medications:
Taken how long?
Current vitamins and other supplements:
Other treatments or health care providers consulted in the past:

How content are you with your life? (1-10; 10=very content) \_\_\_\_\_

What, if anything, would you like to change in your life? \_\_\_\_\_

\_\_\_\_\_

What are the major stresses in your life? \_\_\_\_\_

\_\_\_\_\_

Preferences	Most Liked	Least Liked
Color		
Taste		
Climate		
Time of Day		
Temperature		

**Childhood diseases:** (please circle)

Measles/rubella	Diphtheria	Mononucleosis	Smallpox
German measles	Meningitis	Whooping	Other:
Polio	Mumps	cough	
Rheumatic fever	Chickenpox	Scarlet fever	

**Vaccinations:** (please circle)

Pertussis	Rheumatic fever	Polio	Measles
Mumps	Rubella	Tetanus	Smallpox

Did you have a reaction to any of these vaccinations (e.g. fever)? Yes/No If yes, what type of reaction?

\_\_\_\_\_

\_\_\_\_\_

**X-rays:** (please circle)

Teeth   Stomach   Gall bladder   Back   Chest   Colon   Extremities

Other: \_\_\_\_\_

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EKG? Yes No      When? \_\_\_\_\_

EEG? Yes No      When? \_\_\_\_\_

Blood or plasma transfusions? Yes No      When? \_\_\_\_\_

## **Medical Tests:**

Blood tests:

Saliva hormone tests:

Have you tested positive for Hepatitis A? B? C? D? E?

Other tests:

Significant findings:

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## Health History

Please check off any symptoms you have had in the past or are currently experiencing. Then rate 1-5: (1) rarely, (2) once a month, (3) once a week, (4) a few times a week, (5) daily, next to any box that you check. (Follow the categories from top to bottom of each column before moving across to next column.)

### General

- Chills
- Low Energy
- Dizziness
- Fatigue
- Fevers
  - low
  - high
- Excess thirst
- Insomnia
- Difficulty Falling Asleep
- Frequent Waking
- Sweat spontaneously
- Night sweats
- Afternoon sweats
- Morning sweats
- Lack of sweating
- Recent weight loss/gain
  - How much? \_\_\_\_\_
- Aversion to heat/cold
- Sudden tiredness
  - time of day: \_\_\_\_\_
- Excessive Hair Loss
- Cancer
- Lyme disease

### Eyes

- Glasses/contacts
- Prescription changes
- Blurred vision
- Redness
- Seeing halos
- Light sensitivity
- Discharge
- Tearing or Dryness
- Glaucoma
- Itching
- Blind spots
- Color blind
- Cataract

- Double vision
- Eye pain
- Macular degeneration
- Other \_\_\_\_\_

### Ears

- Earache
- Ear discharge
- Itching Ears
- Excess Wax
- Ear Infections
- Ringing in ears
  - High pitch
  - Low roar
- Vertigo
- Hearing loss
- Deafness
- Other \_\_\_\_\_

### Nose & Sinuses

- Nasal obstruction
- Nasal discharge
- Lost sense of smell
- Injury
- Nosebleeds
- Stuffiness
- Allergies
- Sinus Problems
- Polyps
- Infection
- Other \_\_\_\_\_

### Throat & Mouth

- Recurring sore throats
- Sores on lips
- Sores on tongue
- Taste change
- Teeth pain
- Sensitive to hot/Cold
- Post Nasal Drip

- Hoarseness
- Phlegm in Throat
- Grinding Teeth
- Clicking Jaw
- TMJ syndrome
- Gum problems
  - Bleeding \_\_\_\_\_
  - Painful \_\_\_\_\_
- Silver Fillings
- Gold Crowns
- Dental Cavities
- Other \_\_\_\_\_

### Neck

- Lump
- Pain
- Swollen Glands
- Goiter
- Stiffness
- Other \_\_\_\_\_

### Respiratory

- Asthma
- Wheezing
- Emphysema
- Pneumonia
- Pleurisy
- Hay fever
- Persistent cough
- Coughing blood
- Shortness of breath
- Recurrent bronchitis
- Phlegm in Chest
- Difficulty inhaling
- Difficulty exhaling
- Frequent Colds
- Pain on Breathing
- Last TB test? \_\_\_\_\_
- Last Chest X-Ray \_\_\_\_\_
- Other \_\_\_\_\_

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## Cardiovascular

- Chest pain
- High blood pressure
- Low blood pressure
- Irregular heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins
- Hypochondriac pain
- Distention in chest
- Angina
- Stroke
- Heart Disease
- Rheumatic Fever
- Phlebitis
- Murmurs
- Mitral Valve Prolapse
- Other \_\_\_\_\_

## Gastrointestinal

- Abdominal pain
- Bloating
- Belching
- Gas
- Constipation
- Diarrhea
- Loose stools
- Bloody stools
- Black stools
- Stools float
- Stools sink
- Mucous in stool
- Difficulty swallowing
- Poor appetite
- Heartburn/reflux
- Hemorrhoids
- Indigestion
- Poor appetite
- Stomachache
- Nausea
- Vomiting
- Vomiting blood
- Food Allergies

- Colitis
- Rectal Bleeding
- Appendicitis
- Change in thirst
- Change in appetite
- Change in bowel movements
- Constipation
- Hernias
- Hepatitis
- Jaundice
- Food Aversions
- Food Cravings
- Foods that Disagree
- Number of Bowel Movements per day \_\_\_\_\_
- G/I symptoms relieved by? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Diet/Lifestyle

- Vegan
- Vegetarian
- Eat only organic foods
- Eat some organic foods
- Healthy diet
- Eat fried foods
- Eat meat
- Smoke cigarettes
- Drink alcohol
- Drink coffee
- Use drugs
- Eat lots of sweets
- Take steroids
- Regular exercise
- Excessive exercise
- Meditate

## Weight

- Underweight
- Normal for height
- Overweight
- Very Overweight

## Genitourinary

- Dilute urine
- Dark urine
- Blood in urine
- Cloudy urine
- Profuse urine
- Frequent urination
- Poor bladder control
- Urgency to urinate
- Pain on urination
- Inability to urinate
- Abnormal thirst
- Swelling of hands/ feet/ankles
- Bladder/Kidney Disease
- Kidney Stones
- Pus in urine
- Sugar in urine
- Frequent infection
- Decrease in flow
- Other \_\_\_\_\_

## Musculoskeletal

Pain, weakness, numbness in:

- Arms
- Feet
- Hands
- Joints
- Legs
- Hips
- Neck
- Shoulders
- Pain all over
- Cold limbs
- Knee problems
- Low back pain
- Lack of strength
- Broken bones
- Joint Pain/stiffness
- Arthritis
- Muscle spasm
- Leg cramps
- Other \_\_\_\_\_

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## Skin

- Rashes
- Hives
- Acne
- Lice
- New Moles
- Psoriasis
- Boils
- Scabies
- Thick skin
- Thin skin
- Broken blood vessels
- Blood not clotting
- Bruise easily
- Discoloration
- Dark circles around eyes
- Bags under eyes
- Lumps in groin
- Lumps underarm
- Dry skin
- Brittle nails
- Premature gray hair
- Dry/ brittle hair
- Hair falling out
- "Athletes' Foot"
- Other \_\_\_\_\_

## Neurological

- Dizziness
- Fainting
- Seizures/Convulsions
- Handwriting change
- Paralysis
- Stroke
- Tremor
- Recent clumsiness
- Drowsiness
- Vertigo
- Headaches
- Migraine
- Numbness/tingling
- Paralysis
- Involuntary movements
- Muscle weakness

- Coordination loss
- Concussion/head injury
- Loss of memory
- Poor memory
- Speech problems
- Hallucinations/mental confusion
- Poor concentration
- Loss of Balance
- Other \_\_\_\_\_

## Emotional

- Irritability
- Excessive anger
- Troubling dreams
- Cry uncontrollably
- Feel sad a lot
- Forgetful
- Mind not clear
- Anxiety
- Much fear
- Unrestrained joy
- Terrors
- Difficulty expressing emotions
- Other \_\_\_\_\_

## Reproductive

- Genital pain
- Genital sores
- Increased sex drive
- Decreased sex drive
- Herpes
- Gonorrhea
- Chlamydia
- Syphilis
- Genital infection
- Warts on genitals/HPV
- HIV +
- Pain during intercourse
- Other \_\_\_\_\_

Please check if any apply:

- Sexually Active
- Heterosexual

- Bisexual
- Homosexual
- Transgendered
- Celibate

## Men Only

- Impotence
- Lump in testicles
- Penis discharge
- Nocturnal emission
- Prostate disease
- Premature ejaculation
- "Jock" Itch
- Other \_\_\_\_\_

## Women only

- Age at first menses
- # of pregnancies
- Complications with pregnancies
- # of abortions
- Complications with abortions
- Abnormal pap smear
- Date of last PAP
- Bleed between periods
- Irregular periods
- Flow:
  - Heavy
  - Medium
  - Light
  - Clots
- <25 day cycle
- >35 day cycle
- Endometriosis
- Painful periods
  - Before/After flow
  - low back cramps
  - abdomen cramps
  - thigh cramps
- PMS symptoms:
  - Depression
  - Bloating
  - Appetite Increase
  - Weight Gain
  - Breast tenderness
  - Low back pain

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- Irritability
- Cravings
- Insomnia
- Other \_\_\_\_\_

- Breast lumps
- Contraceptives

- Vaginal discharges
- Menopausal
- \_\_\_\_\_ Age at menopause
- Uterine prolapse
- Facial hair
- Loss of head hair
- May be pregnant
- Frequent yeast infections
- Other \_\_\_\_\_

## Endocrine

- Hyperthyroid

- Racing Heart
- Heat Intolerant
- Excess Sweat
- Insomnia
- Weight Loss
- Hypothyroid
- Slow heart rate
- Cold Intolerant
- Dry Skin
- Constipation
- Weight Gain
- Fatigue
- Hair falling out
- Type I Diabetes
- Type II Diabetes
- On Hormone Therapy
- Hypoglycemia
- Other \_\_\_\_\_

## Blood/Lymphatic

- Anemia
- Easy bruising/ bleeding

- Lymph node swelling
- Blood transfusions
- Other \_\_\_\_\_

## Psycho/Social

- Depression
- Attempted Suicide
- Mood swings
- Anxiety/nervousness
- Tension
- Easily angered
- Easy to cry
- Phobias
- Sleep problems
- Psychiatric or psychological counseling
- Alcohol abuse
- Drug abuse
- Excessive worry
- Difficulty setting boundaries
- Express emotions easily

# *White Lotus Health Center*

**Family History:** Please check those diseases/conditions that apply to any blood relative

	Mother	Father	Siblings	Grand- parents	Others
Cancer					
Skin allergies/Hives					
Eczema/Psoriasis					
Arthritis/gout					
Kidney disease					
Respiratory allergies					
Asthma					
Lung disease/TB					
Liver disease/cirrhosis					
Food allergies					
Gastrointestinal Disease					
Hypoglycemia					
Thyroid Disorders					
Diabetes					
Obesity					
High blood pressure					
Arteriosclerosis/ vascular disease/stroke					
Heart attack/heart disease					
Syphilis					
Gonorrhea					
Depression/Mental Illness					

Please list in order of appearance from your conception, all hospitalizations, surgeries, diseases, major accidents, traumas and scars (emotional, physical and spiritual) that you are aware of. Feel free to write on the back of this page if you need more space.

Age \_\_\_\_\_  
 Age \_\_\_\_\_  
 Age \_\_\_\_\_  
 Age \_\_\_\_\_  
 Age \_\_\_\_\_  
 Age \_\_\_\_\_  
 Age \_\_\_\_\_

Is there anything else that you feel I should know about you? If yes, please feel free to write on the back of this page to elaborate.

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