# Urban Integrative IV and Detox Clinic

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## Personal Health History

**Please print**

Name:_____ D.O.B. _____ ☐ M ☐ F

Address: _____

Phone Number: _____ E-mail Address: _____

Referring Doctor: _____

Address: _____

Phone: _____ Fax: _____

Date of last physical examination: _____

List any medical problems that other doctors have diagnosed:

Surgeries:

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

Other hospitalization:

| Year | Reason | Hospital |
|---|---|---|
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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers, acid reducing medications, antihistamines:

| Name the drug | Strength | Frequency taken | Last taken |
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Allergies to medication including antibiotics, antihistamines etc

| Name the drug | Reaction you had |
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Health Habits

| | | | | |
|---|---|---|---|---|
| Diet | Are you dieting? | | ☐ YES | ☐ NO |
| | If yes, are you on a physician prescribed medical diet? | | ☐ YES | ☐ NO |
| | Number of meals you eat in an average day: | | | |
| Caffeine | ☐ NONE | ☐ COFFEE<br>#Cups/cans per day: | ☐ TEA<br>#Cups/cans per day: | |
| Alcohol | Do you drink alcohol? | | ☐ YES | ☐ NO |
| | If yes, how many drinks per week? | | | |
| | Do you drink wine with dinner? | | ☐ YES | ☐ NO |
| Tobacco | Do you use tobacco? | | ☐ YES | ☐ NO |
| | Cigarettes<br># pks/day | Chew<br>#/day | Pipe<br>#/day | Cigars<br>#/day |
| | Number of years | | Or year quit | |
| Personal Habits | Do you eat late in the evening? | | ☐ YES | ☐ NO |
| | Do you sleep on your left side? | | ☐ YES | ☐ NO |
| | Do you sleep on your stomach? | | ☐ YES | ☐ NO |
| | Do you recline after a meal? | | ☐ YES | ☐ NO |
| | Do you feel drowsy after eating a meal? | | ☐ YES | ☐ NO |
| | Do you have frequent diarrhea? | | ☐ YES | ☐ NO |

Please list supplements that you are taking:

| Supplement | Reason taking |
|---|---|
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Please list naturopathic remedies that you are taking:

| Remedy | Reason taking |
|---|---|
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Please answer the following questions that deal with emotional issues:

| | | |
|---|---|---|
| Is stress a major problem for you? | ☐ YES | ☐ NO |
| Do you panic when stressed? | ☐ YES | ☐ NO |
| Do you experience stomach pain during stressful situations? | ☐ YES | ☐ NO |
| Have you ever been tested for ulcers? | ☐ YES | ☐ NO |
| Do you have trouble sleeping due to stress, abdominal discomfort or reflux? | ☐ YES | ☐ NO |

Please indicate conditions that you are experiencing or have experienced:

<u>Respiratory</u>

Chronic cough
Shortness of breath
Bronchitis
Asthma
Emphysema

<u>Cardiovascular</u>

High blood pressure
Low blood pressure
Congestive heart failure
Heart attack
Phlebitis
Stroke
Heart disease
Pace Maker
Vascular disease

<u>Other conditions</u>

Diabetes: type one
type two
Allergies: food
inhalants
Seizures or epilepsy
Cancer: past
present
Arthritis
Sleeping disorder
Osteoporosis
Prolonged steroid use
Inflammatory disease
Collagen disease
Neck or back injury

<u>Gastrointestinal</u>

Acid Reflux
Gas
Belching
Bloating
Abdominal pain
Irregular stools
Stomach pain
Intestinal
Gall bladder disease
Crohn's Disease
History of Intestinal Blockage, adhesions or bleeding
Gastric Ulcer
Gastritis

<u>Other problems</u>

Sleeping disorder
Recent weight changes
Anemia
Throat
Teeth

<u>Infections</u>

Hepatitis
TB
HIV/AIDS

<u>Women</u>

Pregnant
Date due

What is your general health status?

All information gathered in this questionnaire is kept confidential except for that information which may need to be shared with your referring doctor.

If you agree to this please sign below.

Printed Name: _____

Signature Name: _____ Date: _____

Witness Name: _____ Date: _____