# *Whole Life Medicine*

Washington Urology and Urogynecology Member

12815 120th Ave NE, Suite E, Kirkland WA 98034

P: 425.398.9355 F: 425.486.5913

Web: www.WholeLifeMedicine.net


# HEALTH HISTORY

## Confidential Information

**Name:**_____ Birthdate: _____ Date:_____/_____/_____

**GENERAL**

| | |
|---|---|
| Place of birth | Education |
| Relationship status | Occupation |
| Hobbies | Do you smoke? If yes how much |
| Exercise/recreation | Alcohol use |
| Weight Weight 1 year ago Maximum Weight | Height |
| Date of last Physical Exam | Date of last Eye exam |
| Date of last Colonoscopy | Date of last Prostate /Gyn exam |
| Date of last full Bloodwork | Date of last Bone Density testing |
| Date of last Mammogram | Date of last Dental Exam |
| Describe all serious accidents, severe injuries (include date occurred):<br>☐ None | List all serious illnesses, operations, hospitalizations (include date occurred)<br>☐ None |

**I wish to establish Primary Care here: Y N (Circle) Primary Care Provider: _____**

**Referring Provider: _____ Preferred Pharmacy: _____**

**CHIEF COMPLAINTS: Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:**

_____

_____

**MEDICATIONS:**

| | Take For/How Much | | Take For/How Much |
|---|---|---|---|
| Hormone Therapy | | Birth control | |
| Antibiotics/Antivirals | | Thyroid medications | |
| Heart medications | | Acne medications | |
| Mood medications | | Osteoporosis medications | |
| Sleeping medications | | Steroids | |

**Other medications not listed**:_____

**VITAMINS, MINERALS, HERBS:**

| | | | |
|---|---|---|---|
| | | | |
| | | | |

**ALLERGIES: NO KNOWN ALLERGIES check box ☐**

| | | | |
|---|---|---|---|
| Drug Allergies: | | | |
| Food Allergies: | | | |
| Environmental Sources: | | | |

**CIRCLE IF YOU:**

| | | | |
|---|---|---|---|
| Diet often | Are under excessive stress | Are exposed to chemicals at work | Have thoughts of self harm |
| Have an eating disorder | Use recreational drugs, list: | Spiritual/religious affiliation<br>None (circle)<br>Or please indicate: | Desire weight loss |

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**DIET:** *Please list typical foods consumed on a regular basis.*

Do you have any food restrictions? Y N (Circle) If yes please list: _____

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

Fluids: _____

Alcohol: _____

**PAST MEDICAL HISTORY**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Measles | no | yes | Hives or Eczema | no | yes | chest x-ray | no | yes |
| Mumps | no | yes | Tuberculosis | no | yes | Infectious Mono | no | yes |
| Chickenpox | no | yes | Diabetes | no | yes | Rheumatic Fever | no | yes |
| Whooping Cough | no | yes | Cancer | no | yes | Mitral Valve Prolapse | no | yes |
| Scarlet Fever | no | yes | Polio | no | yes | Stroke | no | yes |
| Diptheria | no | yes | Glaucoma | no | yes | Hepatitis | no | yes |
| Smallpox | no | yes | Hernia | no | yes | Thyroid Disease | no | yes |
| Blood Transfusions | no | yes | Kidney Disease | no | yes | AIDs or HIV+ | no | yes |
| Heart Disease | no | yes | Bleeding tendency | no | yes | Anemia | no | yes |
| Venereal Disease (STD's) | no | yes | Any other disease (please list)_____ | | | | | |

**FAMILY HISTORY: (M = Mother, F = Father, MGM = Maternal Grandmother, PGM = Paternal Grandmother , PGF = Paternal Grandfather)**

| | Who & What Age | | Who & What Age |
|---|---|---|---|
| Alcohol or Drug Problem | | HIV | |
| Allergies | | Kidney Disease | |
| Anemia | | Leukemia | |
| Ankylosing Spondilitis | | Mental Illness | |
| Asthma | | Migraine Headaches | |
| Autoimmune disorders | | Multiple Sclerosis | |
| Cancer | | Early Menopause | |
| Chronic Lung Disease | | Obesity | |
| Diabetes | | Osteoporosis | |
| Eczema | | Psoriasis | |
| Epilepsy | | Parkinson's disease | |
| Glaucoma | | Rheumatoid Arthritis | |
| Gout | | Stroke | |
| Heart Disease | | Thyroid Disease | |
| Hepatitis | | Tuberculosis | |
| High Blood Pressure | | Ulcers | |
| High Cholesterol | | Other | |

| | Present age /or Age of death | If living, health (good, fair, poor) | If deceased, cause of death |
|---|---|---|---|
| Father: | | | |
| Mother: | | | |
| Siblings: | | | |
| Spouse: | | | |
| Children: | | | |

Please list any other information you think is important: