Institute of Complementary Medicine
1600 E Jefferson Street, Suite 603
Seattle, WA 98122-5649

FOC Health History - ICM

Health History

Reason for office visit today

Whom may we thank for referring you today?

Do you have another primary care provider?

Date of last physical exam

Previous or referring doctor:

Sex/Gender

Marital Status

Number of Children, and ages

Personal Health History

List any medical problems that other doctors have diagnosed:

Recent Laboratory procedure performed (ex., stool analysis, blood and urine tests, imaging tests):

Outcome:

Please list any previous hospitalizations, surgeries, or accidents with date.

Please list your current weight, lowest adult weight, and highest adult weight:

List any Drug Allergies

Current Medications (prescription or over-the-counter) with dosage:

Current Supplements with dosage

Family Health History

Choose Relevent Family Health History (Mother, Father, Sibling, or Grandparent)

- ☐ Alcoholism
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Migraine
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Others _____
- ☐ Allergies
- ☐ Autoimmune
- ☐ Depression
- ☐ Eczema
- ☐ High Cholesterol
- ☐ Mental Illness
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Thyroid

Health Habits and Personal Safety

Alcohol:

Do you drink alcohol? ☐ Yes ☐ No

If yes, what kind? _____

How many drinks per week? _____

2. Are you concerned about the amount you drink? ☐ Yes ☐ No

3. Have you felt you ought to cut down? ☐ Yes ☐ No

4. Do people annoy you by criticizing your use? ☐ Yes ☐ No

5. Have you felt bad/guilty about your use? ☐ Yes ☐ No

6. Have you ever had to have an eye-opener? _____

Exercise:

Please describe your current exercise practice: _____

Diet:

List any special diet you follow _____

List any foods you avoid _____

How much water do you drink per day

Please list a typical daily diet (breakfast, lunch, dinner, snacks, desserts)

How many caffeinated drinks per day do you drink and in what form (soda/tea/coffee)

Sleep:

Do you have any problems with your sleep, if so please describe?

Average number of hours of sleep:

Rate your current energy on a scale of 1-10 (10=highest): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Rate your current stress level on a scale of 1-10 (10=highest) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What do you do to manage your stress?

Do you have a spiritual practice? What?

Tobacco

Do you use tobacco product? ☐ Yes ☐ No

Have you ever used tobacco products? ☐ Yes ☐ No

How many year have you used tobacco? _____

What was/is your daily usage? _____

Drugs:

Do you use recreational or street drugs ☐ Yes ☐ No

Have you ever used street drugs with a needle? ☐ Yes ☐ No

Sex:

Are you currently sexually active? ☐ Yes ☐ No

Gender and number of partner(s): _____

Are you trying for a pregnancy? ☐ Yes ☐ No

If you are not trying for a pregnancy, list contraceptive or barrier method used: _____

Have you been sexually active in the past? ☐ Yes ☐ No

Gender of partner(s): _____

Any problems or concern with sexual function or desire? ☐ Yes ☐ No

If yes please explain _____

_____

_____

_____

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ☐ Yes ☐ No

Personal Safety

Do you live alone? ☐ Yes ☐ No

Do you have frequent falls? ☐ Yes ☐ No

Do you have vision or hearing loss? ☐ Yes ☐ No

Do you wear your seat belt? ☐ Yes ☐ No

Do you wear your helmet? ☐ Yes ☐ No

Is the battery current in your smoke detector? ☐ Yes ☐ No

Would you like information on the preparation of these? ☐ Yes ☐ No

Do you have an Advance Directive or Living Will? ☐ Yes ☐ No

"Gun Violence is a major public safety and health issue in this country. Would you like information on the proper/safe storage of guns?" ☐ Yes ☐ No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Yes ☐ No

When was the last time you went to the dentist? _____

Mental Health

Is stress a major problem for you? ☐ Yes ☐ No

Do you feel depressed? ☐ Yes ☐ No

Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you intentionally harmed yourself?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Have you seriously thought about hurting others?	☐ Yes	☐ No
Do you feel you have an adequate support system?	☐ Yes	☐ No
Are you currently seeing a counselor?	☐ Yes	☐ No
If so, who?	_____	
In the past 2 weeks, have you been or had little interest or pleasure in doing things?	☐ Yes	☐ No
In the past 2 weeks have you been feeling down, depressed or hopeless?	☐ Yes	☐ No

Female Only

Do you have any problems with your menses? If so please explain _____

Number of pregnancies? Number of live births? _____

Do you have any problems with urination? If so please explain? _____

Do you have any menopausal symptoms you are concerned about (hot flashes etc.)? If so please explain _____

Do you have any breast tenderness, discharge etc? If so please explain.

Have you been instructed on breast-exams? ☐ Yes ☐ No

Are you currently pregnant or breast feeding? ☐ Yes ☐ No

When was you past PAP?

Have you had an abnormal PAP ☐ Yes ☐ No

Have you had a mammogram, if so when?

Male Only

Do you have any problems with urination (example getting up multiple times per night, pain, burning etc.)? If so please explain

Do you have any problems with sexual function? Is so please explain

Do you have any testicular pain or swelling? ☐ Yes ☐ No

Have you been instructed on testicular self-exams?

MEDICAL HISTORY within the last 6 months

Allergic/Immunologic

Please choose your personal medical history

- ☐ Arthritic flare-up
- ☐ Crohns
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Celiac Disease
- ☐ Ulcerative Colitis

Eyes

Please choose your personal medical history

- ☐ Blurred Vision
- ☐ Loss of Vision
- ☐ Pain or soreness in or about the eyes

Dermatologic (Skin)

Please choose your personal medical history

- ☐ Eczema
- ☐ Pruritis (itching)
- ☐ Rash
- ☐ Hives
- ☐ Psoriatic flare-up

Ears, Nose, Mouth, Throat

Please choose your personal medical history

- ☐ Cough, chronic
- ☐ Ear infection
- ☐ Hoarseness
- ☐ Ringing in ear
- ☐ Sore throat
- ☐ Difficulty with hearing
- ☐ Epistaxis (nosebleeds)
- ☐ Hypoglycemia
- ☐ Sinus problem

Respiratory

Please choose your personal medical history

- ☐ Asthma
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of breath

Cardiovascular

Please choose your personal medical history

- ☐ Ankle Swelling
- ☐ Elevated blood pressure
- ☐ Irregular heartbeat
- ☐ Palpitations
- ☐ Shortness of breath at night
- ☐ Syncope (fainting)
- ☐ Chest Pain
- ☐ Fatigue
- ☐ Murmur (heart)
- ☐ Shortness of breath at rest
- ☐ Shortness of breath with exercise
- ☐ Varicose veins

Gastrointestinal

Please choose your personal medical history

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Weight loss, unintentional
- ☐ Blood in stool
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Melena (dark, tarry stools)
- ☐ Swallowing difficulty
- ☐ Weight gain
- ☐ Yellowing of skin

Genitourinary

Please choose your personal medical history

- ☐ Discharge (from urethra)
- ☐ Urinary difficulty
- ☐ Urinary output low
- ☐ Painful urination
- ☐ Urinary incontinence
- ☐ Urinating frequently at night

Musculoskeletal

Please choose your personal medical history

- ☐ Back pain (chronic)
- ☐ Gout attack
- ☐ Neck pain
- ☐ Foot pain
- ☐ Leg pain

Endocrine

Please choose your personal medical history

- ☐ Cold intolerance
- ☐ Excess hair growth
- ☐ Hyperglycemia
- ☐ Unusual fatigue
- ☐ Dry Skin
- ☐ Extreme thirst
- ☐ Thyroid disease

Hematologic

Please choose your personal medical history

- ☐ Anemia
- ☐ Bruise Easily

Neurologic

Please choose your personal medical history

- ☐ Difficulty concentration
- ☐ Dizziness
- ☐ Headache
- ☐ Numbness
- ☐ Seizures
- ☐ Tingling
- ☐ Tremors

Psychiatric

Please choose your personal medical history

- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Mood changes

Other

Please list any other past medical problems _____

_____

_____

_____

For Men

Please choose your personal medical history

- ☐ BPH
- ☐ Decreased sex drive
- ☐ Problems with urination
- ☐ Infertility
- ☐ Prostate cancer
- ☐ STD
- ☐ testicular pain/swelling

For Women

Please choose your personal medical history

- ☐ Breast cancer
- ☐ Decreased sex drive
- ☐ Endrometriosis
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Infertility
- ☐ Menstrual irrelgularities
- ☐ Pelvic inflammatory disease
- ☐ PMS
- ☐ STD
- ☐ Vaginal infections

Thank you for taking the time to fill out this form completely. We look forward to working with you.

Today's Date _____