Name: ____Date: ______________________

BHRT & Integrative Wellness, LLC
New Patient Medical History

Today's Date______________________

First Name:___________________________ Last Name: ____

What name do you like to be called? ____________________________________

Birth Date:_________/________/_________ Age: ______________

What is the best way to contact you? ____

Primary care provider: ____

(*Your answers to the following questions will help better understand your health concerns. If you cannot remember specific dates, please answer to the best of your ability)

What is your single priority for today's visit?

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____
____

What is your goal over the next 1-3 months?

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____
____

What is your long-term goal?

____
____

What are you willing to do to improve your health?/What will you NOT do? (Please be specific. Examples could include food, beverages, vitamin products, exercise, habits etc. "Anything" is not specific enough.)

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____

Name: ____Date: ______________________

What are your specific expectations of BHRT & Integrative Wellness, LLC?

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____
____

What additional information are you seeking?

____
____
____
____

How would you rate your general health? (Place (X) by your desired answer)
Excellent________________ Good_________________ Fair_________________
Poor________________

WHY?____
____
____
____
____

Your Medical history (examples, circle or write-in): Alcoholism or other addictions, Allergies, Anemia, Arthritis, Asthma or Exercised induced asthma, Bleeding/clotting problems, Cancer, COPD, Diabetes, Epilepsy, convulsions, or seizures disorder, Chronic ear, sinus, tonsil, or chest infections, Gallstones, Gout, elevated blood pressure**,** cardiovascular disease, heart attack, chronic chest pain or angina, elevated cholesterol, heart murmur, irregular or skipped beats, rheumatic heart disease, heart failure, sleep apnea, chronic swelling of the legs/feet, Pneumonia, Hepatitis A, B, or C, Herpes, Irritable bowel syndrome, Inflammatory bowel disease, Hemorrhoids, Gallstones, Kidney diseases, frequent urinary tract infections/vaginal yeast infections, kidney cysts, kidney stones, kidney failure, Mental health concerns-depression, anxiety, ADD, ADHD, OCD, Bipolar disorder etc., Chronic migraines, Eczema, Psoriasis, Rosacea, Skin cancer, Vitiligo, STD's, Strokes/TIA, Thyroid problems, Vision or hearing problems, Tuberculosis, Arthritis (Rheumatoid, Osteo.), Osteoporosis/Osteopenia etc.

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Name: ____Date: ____________________

Your Surgical History (examples)**:** Tonsillectomy, Appendectomy, Gall Bladder, Hernia, Hysterectomy, Vasectomy, etc.)

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FAMILY HISTORY:

Mother: Age____________________ Medical history: ____
____
____

Father: Age___________________ Medical history: _______________________________________
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____

Siblings: How many? __________ Medical history: ____
____

Maternal grandparents' medical history:
____
____

Paternal grandparents' medical history:
____
____

Other family members with pertinent medical history:
____

SOCIAL HISTORY/Health Habits:

- What is your occupation:____
- Marital status: ____
- With whom do you live? (Include children, parents, relatives, and/or friends): ______________________

Name: ____Date: ___________________

- Do you have children? Yes __________ No __________
  What ages?____

- Do you have any pets or farm animals? Yes______________ No______________
- What kind? ____
  If yes, where do they live? 1. Indoors __________ 2. Outdoors__________
  3. Both indoors and outdoors __________

- Have you used tobacco? __________________________
  What kind and for how long? ____

- How much alcohol do you consume? ____
  Do you feel the need to cut down? ____

- Do you use recreational/Illicit drugs? (What kind and for how long?) _______________________________

- Occupational exposures to chemicals of heavy metals? (What kind and how long was the exposure?)
  ____

- Please describe your sleep most nights? ____
  ____

- Have you lived or traveled outside of the United States, especially to developing countries?
  Yes_________ No_________ If so, when, where and for how long? ____________________________

____

- Current Exercise: (What kind, how often, time frame?) ____
- How is your energy after exercise? ____

- What are your hobbies? ____

- Have you or your family recently experienced any major life changes? Yes______________ No__________
  If yes, please comment if you wish: ____
  ____

- Have you experienced any recent major losses in your life? Yes______________ No______________
  If so, please comment as you wish: ____

- How important is religion (or spirituality) for you and your family's life?

a. _____ Not at all important

b. _____ Somewhat important

c. _____ Extremely important

Name: ____ Date: ______________________

CURRENT MEDICATIONS:

Medication Name	Dosage	Date Started
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Regular Over-the-Counter medications:

____

____

Current SUPPLEMENTS/VITAMIN products: (example: calcium carbonate, calcium citrate, ascorbic acid, Vit. C ascorbate etc.)

Name of Product	Dosage (mg/IU)	Name of Company making product
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ALLERGIES/SENSITIVITIES:

Medications: ____

____

Food/Environmental Allergies: ____

____

Name: ____Date: _____________________

Have you used antibiotics on a chronic basis? (Examples: chronic sinus infections or other infections, treated for acne etc.) Yes___________________________ No___________________________

MOST RECENT HEALTH SCREENING: (Year, where performed and who performed the screening)

Most recent eye exam: ____

Most recent hearing exam:____

Most recent dental exam: ____

PAP (Female): ____

Mammogram (Female): ____

Prostate exam (Male)____

Colonoscopy: ____

EKG/Heart stress test: ____

Year of last normal TB test: ____

Vaccinations received in the last 10 years:

____

CURRENT HEALTH CONCERNS: (**please circle and explain briefly what you would like to review at your first appointment**)

GENERAL: Generalized fatigue, cancer, Mononucleosis/EBV, unusual fever, chills, sweats, unusual weight loss/gain, exposure to toxic chemicals or heavy metals, chronically enlarged lymph nodes, anemia etc.

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EYES: Chronic double vision, cataracts, glaucoma, macular degeneration, chronic watery/itchy eyes, chronic dark circles under/around the eyes, spots in the field of vision, difficulty with night vision, eye pain, etc.

Name: ____Date: ______________________

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EARS: Chronic ear infections, changes in hearing or hearing loss (which ear?), chronic ear ringing (tinnitus), chronic itchy ears, chronic drainage from the ears, etc.

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NOSE: Distorted sense of smell, chronic sinus infections, chronic stuffy nose, hay fever, excessive mucous production: etc.

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THROAT/DENTAL: Distorted sense of taste, chronic sore throat, chronic voice hoarseness, chronic gum problems/disease, frequent canker/cold sores, chronic voice hoarseness etc. Tongue concerns? Root canal(s)/what teeth? Metal (amalgam) fillings – how many? Did you wear braces/for how long and at what age?

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NEUROLOGIC: Difficulty falling asleep, Difficulty maintaining sleep, Daytime sleepiness, Night waking, Chronic night terrors, Chronic dizziness, blackouts, lightheadedness/vertigo, Migraine or other chronic headache, Head trauma. Lack of dreaming?

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LUNGS: Chronic cough/dry or productive, chronic wheezing, chronic congestion, chronic shortness of breath, chronic Bronchitis, sleep apnea etc.

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Name: ____Date: ______________________

HEART: Chronic chest pain, dizziness/fainting spells, lower leg/ankle swelling, elevated blood fats (cholesterol, triglycerides) etc.

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GUT/GI: Difficulty swallowing, chronic heartburn, excessive belching/gas, distention/bloating after meals, chronic nausea or vomiting, stomach/intestinal ulcers, chronic diarrhea, blood in stools, mucous in stools, fat in stools, undigested food in stool, chronic constipation, fatty liver etc.

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MUSCLES/BONES/JOINTS: Tension Headache, restless legs, chronic muscle cramps (where/when?), chronic pain (where?) etc.

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____

SKIN: Changes in skin, changes in hair, changes in fingernails/toenails (brittle, curved up, pitted, ridged, soft, thickened, changes in color), changes in fingernails/toenails (brittle, curved up, pitted, ridged, soft, thickened, changes in color), chronic rashes/hives, change in moles, shingles etc.

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KIDNEYS/BLADDER: Chronic urine leaking, chronic urinary tract infections, chronic blood in the urine, chronic pain urinating, chronic kidney pain, kidney stones, kidney cysts etc.

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Name: ____Date: ___________________

REPRODUCTIVE (FEMALE):
Age at first menses: ____________________

First day of last menstrual cycle: ______________________

Number of pregnancies: ____________ Number of children: ______________

Miscarriages: _____________ Termination(s): ___________________

Contraceptive method: ______________________________

Changes in menstruation (heavy, irregular, absent, scanty, spotting between periods):
____

PMS symptoms: ____

Changes in libido?____

Uterine fibroids, Endometriosis, Ovarian cysts?
Vaginal dryness, discharge, odor, itching, pain?
Chronic breast tenderness, Breast cysts/lumps?
Chronic yeast infections?

REPRODUCTIVE (MALE): Changes in libido, penile discharge, pain or problems with ejaculation, pain or problems with erections, cysts/lumps in testicles etc.

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ENDOCRINE: Little or no sweating, chronically cold hands/feet, internal cold intolerance, internal heat intolerance, high/low thyroid, hypoglycemia, etc.

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MENTAL HEALTH/MOODS: Current suicidal thoughts, anxiety, panic attacks, depression, difficulty concentrating, fearfulness, irritability, bipolar disorder etc.

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Name: ____Date: _____________________

NUTRITIONAL:
How would describe your current eating habits? (Place (X) by your desired answer)
Junk food ___________ Standard American Diet ____________ Majority of processed food ___________

Majority of whole food ___________ Vegetarian ___________ Other ______________________________

Are you currently on a special diet?
____

Typical breakfast
____

Typical lunch:
____

Typical dinner:
____

What do you snack on?
____

What foods do you gravitate towards?
____

What foods do you avoid or have aversions to?
____

How do you feel after eating onions, garlic, shallots, leeks, chives, broccoli, cauliflower, and/or cabbage?
____

Caffeine intake (amount/what kind/how often):
____

Water intake (amount/kind-tap, bottled, well, or filtered):
____

ELECTROMAGNETIC EXPOSURE:
Do you sleep on a waterbed or use an electric blanket on your bed? Yes ___________ No _______________

What is your cumulative exposure (minutes/hours) to electronic devices daily? __________________________

Name: ____Date: ______________________

Any additional comments:
____
____
____

____   __________________________
Signature   Date

Thank you for taking the time to provide this information so
we may make a realistic plan for your health goals.