

Watson Wellness

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HEALTH INVENTORY

Name _____ Date _____

Age _____ Date of Birth _____ Place of birth _____

Sex _____ Marital Status _____ Blood type _____ Occupation _____

Reason for Visit _____

Are you seeing another Doctor, Health Practitioner, and/or Therapist? (If yes, whom?) _____

Medications _____

Allergies to Medications _____

Supplements _____

Surgeries _____

Injuries _____

What are you goals for your health _____

Have you had any of the following problems? Please explain in space below

GENERAL: Recent weight gain or loss Fever, Chills, Fatigue Loss of appetite

Anemia, Immune dysfunction, Autoimmune disease, Cancer , Environmental sensitivity, Chemical exposure

Other _____

EYE,EAR,NOSE THROAT:: vision changes, blurry vision, eye pain, discharge, light sensitivity, glaucoma, dry eyes, ear pain, hearing loss, ringing in ears, discharge. excess wax, nose bleeds, congestion, allergies, sinusitis, loss of smell, Sore throat, trouble swallowing, hoarseness, tonsillitis

Other _____

RESPIRATORY: Cough, shortness of breath, wheezing, asthma, bronchitis, pneumonia

Other _____

GASTROINTESTINAL: nausea, vomiting, constipation, abdominal pain, hemorrhoids, blood in stool,black stools, jaundice, hepatitis, pancreatitis, gall bladder disease,diverticulitis, pararsites

Other _____

HEART/BLOOD VESSELS: chest pain, palpitations, heart murmur, shortness of breath, swollen ankles, heart attack, angina, varicose veins,

Other _____

KIDNEY/BLADDER: infections, stones, frequent urination

Other _____

BONES,MUSCLES JOINTS: fractures, back pain, joint pain, swollen joints, muscle cramps, stiffness, muscle pain, arthritis, fibromyalgia, osteoporosis, osteopenia

Other _____

ENDOCRINE/GLANDS: thyroid disease, adrenal weakness, heat or cold intolerance, excessive thirst or urination, low blood sugar

Other _____

NEUROLOGIC :Headaches, migraines, weakness, dizziness, numbness, tingling, fainting spells, tremors, seizures

Other _____

SKIN/HAIR: rashes, itching,eczema, cold sores, skin cancer, hair loss

Other _____

PSYCHOLOGICAL:depression, sadness, feeling overwhelmed, anxiety difficulty sleeping, memory loss, obsessive thoughts, fears, loss of pleasure in life

Other _____

INFECTION/SEXUAL DISEASES: Epstein-Barr, CMV, Mycoplasma, Herpes, HPV, HIV, AIDS, Gonorrhea,

Chlamydia, Syphilis, Tuberculosis, Meningitis Childhood diseases: Measles Mumps Chicken pox, Whooping cough

Other _____

HEALTH INVENTORY continued

Health Habits:

Do you smoke cigarettes? _____ For how long? _____ How many per day? _____
Do you drink caffeinated beverages? _____ How many per day? _____
Do you drink alcohol? _____ What type? _____ How often? _____
Do you exercise? _____ What type? _____ How often? _____
Do you have any dietary restrictions? (vegetarian, food allergies) _____
How often do you eat sugar? _____ Fast food? _____
Do you have a spiritual practice _____

Preventative Procedures:

Mammogram _____
Pap smear _____
Chest X-ray _____ Calcium Score _____ EKG _____
Hemocult _____
Sigmoid/Colonoscopy _____
Vaccinations: Tetanus _____ TB _____ Pneumovax _____
Shingles _____ HPV _____ Pertussis _____ Flu shots _____
Other Immunizations _____

Family History:

Are your parents alive, _____ if deceased please mark age at death
Age of Mother _____ Age of Father _____ Siblings _____

Have any members of your family had the following diseases? (Please indicate whom.)

Cancer _____ Arthritis _____ Heart Disease _____
Stroke _____ High blood pressure _____ Diabetes _____
Allergies/Asthma _____ Emphysema _____ Tuberculosis _____
Alzheimer's Disease _____ Parkinsons _____ Mental Illness/Suicide _____
Other _____

For Women Only:

Age of onset of first menses _____ Are your periods regular? _____
Length of time between cycles? _____ How many days do you bleed? _____
No. of pregnancies _____ No. of Miscarriages _____ No. of living children _____
Cramps with Menses _____ PMS _____ Breast Problems _____ Vaginal infections _____
What form of birth control do you use? _____
Have you had an abnormal Pap? _____ If yes, please describe type of problem and the treatment _____

Have you had any other problems with ovaries, uterus, breasts or sexual problems _____

For Men Only:

Have you had prostate problems? _____ infections? _____ enlargement? _____
Have you had any of the following symptoms?
Waking more the once at night to urinate? _____ frequent urination? _____
Decrease in flow of urination or dribbling _____
Burning or discharge from the penis? _____ testicular swelling or lumps? _____
Have you had a PSA? _____ was it normal? _____ sexual problems? _____