WATSON WELLNESS 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, hepatits, 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 thrist 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, Syphylis, Tuberculosis, Meningitis Childhood diseases: Measles Mumps Chicken pox, Whooping cough
Other_____

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_____
Hemoccult _____
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 _____
Alzheimers 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? _____