The Salerno Center
for Complementary Medicine

CONFIDENTIAL HEALTH HISTORY

Once again, welcome and thank you for choosing The Salerno Center. The following is an integral part in our collaborative journey to better health and wellness. Please take the time to carefully complete each section. The last page is left blank for any relevant additional information you would like to provide to your physician.

Full Name			Nickname/AKA
Date of Birth	Age	Blood Type	☐ Male ☐ Female
Marital Status		Sexual Orientation	
Nationality		Occupation	

PRIMARY CONCERN

Please use the following to best describe the primary reason you are seeking medical care today.

Concern	Symptoms	Onset/Duration

SYMPTOMS

Please use the following to best describe your primary issues and when they began or how long they have been a concern

Health Issue	Symptoms	Onset/Duration

MEDICATION AND SUPPLEMENTS:

Please list all medications and supplements that you take on a regular basis.

Medication/ Supplement	Purpose	Dose	Frequency	Response

Name	Date

ALLERGIES:

Please list any allergies to supplements, medications, foods, or environmental substances:.

Allergy	Reaction

MEDICAL HISTORY:

Please detail any hospitalizations and/or surgeries you have had:

Reason for Hospitalization &/or Surgery	Outcome	Date

Please list any major illnesses that you currently have or have had in the past:

Illness	Date of Onset	Date of Resolution

Are you presently under the care of a physician, chiropractor, naturopath, acupuncturist, or other health practitioner?

Practitioner	Specialty	Location	Telephone

WOMEN

Age of menstrual onset?		Last menstrual period?		Are your periods regular?	
Days between periods?		Duration of period?		Number of pregnancies/children?	

Name	Date

HEALTH MAINTENANCE:

Please list the date of the most recent of the following, and bring whatever results you may have with you to your appointment.

	Date		Date		Date
Complete physical		Vision test		**WOMEN:**	
EKG		Tetanus booster		Pap smear	
Cardiac stress test		Hepatitis B vaccine		Mammogram	
MRI/CT				Breast Exam	
X-rays		**MEN:**		Bone density	
Dental		Prostatic exam			
Cholesterol test		PSA blood test		**CHILDREN:**	
Stool blood test		Bone density		Immunizations	
Colonoscopy					

DIETARY HABITS:

Please list a record of what you would normally eat and drink in a given day, indicate if you often skip a meal:

BREAKFAST

Food	Beverages

LUNCH

Food	Beverages

DINNER

Food	Beverages

SNACKS/SWEETS

Food	Beverages

Name	Date

How many times per day/week do you eat the following foods?

Beef		Chicken		Fish		Pork	
Eggs		Cheese		Fruit		Vegetables	
Salad		Sugar		Other			

What do you drink in between meals?

What is your current weight?		What is your ideal weight?	
What is the most you have ever weighed?		What is the least you have ever weighed ?	

Are you trying to loose weight?		Gain weight?		Have you dieted in the past?	

<u>PERSONAL HABITS:</u>

TOBACCO:

Do you currently or have you ever smoked?		If yes, what?	

How much?		How long?		When did you quit?	

ALCOHOL:

Do you currently drink alcohol?		If so, what and how often?	
Have you ever had a drinking problem?		If yes, how long sober?	
Do you still regularly attend meetings of any kind?		What kind of meeting?	

RECREATIONAL DRUGS:

Do you use recreational drugs?		If so, which ones?	
Have you ever used intravenous drugs?		If yes, when was the last time?	
Have you ever been treated for a drug problem?		Are you still in treatment?	

EXERCISE:

Do you currently exercise?		How often?		Session Length?	
What exercise do you do?					

MISCELLANEOUS:

Do you drink coffee?		How many 8 ounce cups per day?	

Do you take laxatives?		Which kinds?		How often?	
Do you use antacids?		Which kinds?		How often?	

How many hours of sleep do you get each night?		Do you feel rested in the am?	
Do you have problems falling or staying asleep?		Do you have night sweats?	
Do you wake frequently?		What time?	
Are you sexually active?		Do you use condoms during sexual intercourse?	

Name	Date

CHILDREN ONLY:

Does your child relate well to others in school?		At home?		At Play?	
Have you ever been told your child has an attention problem?		Was She evaluated?			
Does your child have earaches?		How many?		How often?	
How many times has your child been on antibiotics?					

PSYCHOLOGICAL/SPIRITUAL ASSESSMENT:

Do you consider yourself under stress?		At home?		At Work?	
How much does this stress interfere with your life?					
Are you currently in a satisfying relationship with someone?	☐ Very Much ☐ Mostly ☐ Somewhat ☐ Not at All				
Do you frequently become depressed?		Have you ever been treated for depression?			
Do you have wide mood swings?		Do you consider yourself compulsive?		Impulsive?	
Are you anxious?		Do you get riled easily?			
Do you have a religious or spiritual practice?		If yes, what?			

FAMILY HISTORY:

Please list ages, health problems and cause of death if deceased:

Family Member	Living (age)	Health Issue(s)	Deceased (age)	Cause
Mother				
Father				
Brother(s)				
Sister(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Name	Date

REVIEW OF BODY SYSTEMS:

Do you have a present or past history of any of the following? Please check.

Symptoms	Present	Past
Neurologic:		
Recurrent headaches		
Migraines		
Dizziness		
Speech difficulties		
Visual disturbances		
Muscle weakness		
Memory loss		
Seizures		
Ear/Nose/ Throat:		
Wear glasses or contacts		
Double vision		
Cataracts		
Hearing loss		
Ringing in ears		
Ear infections		
Sinus problems		
Frequent sore throats		
Hoarseness		
Difficulty swallowing		
Decreased ability to smell		
Cardiovascular:		
Chest pains		
Palpitations		
Heart attack		
Murmurs		
Rheumatic fever		
High blood pressure		
Atrial fibrillation		
Fainting		
Ankle swelling		
Leg pain while walking		
Respiratory:		
Shortness of breath		
Wheezing		
Chronic cough		
Blood in sputum		
Bronchitis		
Emphysema		
Pneumonia		
Asthma		
Genito-Urinary:		
Frequent Urination		
Blood in urine		
Pus in urine		
Nighttime urination		
Pain on urination		
Kidney infections		
Kidney stones		

Symptoms	Present	Past
Prostate infections		
Enlarged prostate		
Painful intercourse		
Gastro-Intestinal:		
Nausea		
Vomiting		
Abdominal pains		
Heartburn		
Recurring diarrhea		
Frequent constipation		
Changes in bowel habit		
Blood in stools		
Black stools		
Gallstones		
Ulcers		
Hepatitis		
Gynecological:		
PMS		
Irregular periods		
Infertility		
Gestational diabetes		
Menopause		
Skin:		
Skin growths		
Change in color of growth		
Skin cancer		
Hives		
Rashes		
Eczema		
Psoriasis		
Athlete’s foot		
Hair loss		
Nail fungus		
Canker sores		
Miscellaneous		
Cancer		
Where?		
Diabetes		
Thyroid problems		
STD		
Chronic infections		
Where?		
Herpes		
Anemia		
Allergies		

Name	Date

Please use the following space for additional information.