



Health History Summary

Confidential

Date: _____

PATIENT INFORMATION

Patient Name: _____ Age: _____ Date of Birth: _____

Gender: _____ Ethnicity: _____ Blood Type: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____ May Dr. Mundair contact you via e-mail? Y N

Phone (home): _____ (Work): _____ (Cell): _____

May I leave you confidential voice-mail messages at any of the above numbers?

No Yes (specify) Home Work Cell

Preferred form of contact: _____ Best Time(s) to reach you: _____

Occupation: _____ (full/part time) Employer: _____

Emergency Contact: _____ Phone #: _____

Relationship to Contact: _____

Last Physician or Health Practitioner Seen: _____ When? _____

Will Dr. Mundair be acting as your Primary Care Physician? (Please circle) Y N

If No, What is the name of your Primary Care? _____

Contact Information for Primary Care: _____

Last Blood testing was done when? _____ What kind? _____

Are you currently seeing (a) medical specialist (s)? Y N Reason? _____

Name and contact information for the medical specialist (s):

Do you have any known contagious diseases at this time? Y N

If yes, what? _____

How did you hear about Dr. Jaspreet Mundair? _____

What do you expect from your visit today? Please be as thorough and specific as necessary.

How willing are you to make changes in your diet, lifestyle, etc. to feel better? (please circle)

1-----2-----3-----4-----5
Not Willing to Make Changes Very Willing to Make Changes

CURRENT HEALTH PICTURE

What is the main reason for your visit? _____

If you have a specific health condition, please describe in detail:

When was the very first time that you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation?

How long has your main concern been troubling you? _____

Is your current main concern getting [better, worse, same] and for how long?

List, in order of importance, other health concerns:

1. _____ Length of Time _____

2. _____ Length of Time _____

3. _____ Length of Time _____

4. _____ Length of Time _____

Have you ever seen a Naturopathic Physician, Chiropractor, Acupuncturist, or other alternative health practitioner for your current main concern? Y N

What therapies were used and what were the results? _____

How long has it been since you felt really good? _____

HEALTH HISTORY

The general state of your health is (circle one): Excellent Good Average Fair Poor

On average describe your energy level from 1-10: _____ (10 is highest, 1 is lowest)

When during the day is your energy the best? _____ Worst? _____

What is your current approximate: Weight: _____ Height: _____ Weight 1 year ago: _____

As an adult, what has been your max weight (not including pregnancy): _____ min _____

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Please circle the most significant one.

1. _____ Date _____

2. _____ Date _____

3. _____ Date _____

4. _____ Date _____

5. _____ Date _____

Are you currently working with a professional counselor, psychologist, social worker, pastor, or other therapist? _____ Have you in the past? _____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart disease:
Specify Type: _____ | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Cancer: (specify): _____ |
| <input type="checkbox"/> Asthma/Lung disease | <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> High blood pressure |
| | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Diabetes |
| | | <input type="checkbox"/> Other: (specify): _____ |

Please note when and why you have had each of the following:

X-rays: _____	Last Eye Exam: _____
Ultrasounds: _____	MRI/Cat Scans: _____
TB Test: _____	Accidents: _____
HIV Test: _____	Last Dental Visit: _____

Did you have the following **Disease (D)**, **Get Immunized (I)**, or **Neither (N)**:

Measles:	D I N	Chicken Pox:	D I N	Hemophilus (Hib):	D I N
Tetanus:	D I N	Whooping Cough:	D I N	Rubella:	D I N
German Measles:	D I N	Mumps:	D I N	Hepatitis B:	D I N

Reactions to any vaccinations: _____

Medications: Please give full name, dosage, and length of time that you have been taking medication

<u>Pharmaceuticals</u>	<u>Dose</u>	<u>When/ How often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Vitamins/ Herbs</u>	<u>Dose</u>	<u>When/How often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies/Sensitivities: Please list any allergies/sensitivities to drugs, herbs, foods, animal or other and what reaction it causes **Check here if none**

Substance	Reaction
_____	_____
_____	_____
_____	_____

Previous Surgeries and Hospitalizations:

Please list all prior operations with dates (also include Cesareans and outpatient surgeries):

FAMILY HISTORY

Please circle **Yes** or **No** to indicate if any member of your family has had these diseases.

(Family history includes your parents, grandparents, siblings, and your children.)

Relationship To You	Relationship To You
Blindness yes / no _____	Glaucoma yes / no _____
Cataract yes / no _____	Heart Disease yes / no _____
Diabetes yes / no _____	High Blood Pressure yes / no _____
Cancer yes / no _____	Stroke yes / no _____
Thyroid Disease yes / no _____	Macular Degeneration yes / no _____
Arthritis yes / no _____	Other Inherited Disease _____

SOCIAL

Which of the following do you currently use (please indicate amount, including how often, how much and for how long)

Alcohol: No Yes # Drinks/week _____

Tobacco Use:

Caffeine intake:

Cigarettes Never Quit Date: _____

None Coffee/tea/soda _____ cups/day

Current Smoker: packs/day _____ # of yrs _____

Laxatives _____

Other Tobacco: Pipe Cigar Snuff Chew

Sedatives _____

Are you interested in quitting? No Yes

Do you use any recreational drugs? No Yes

Ever used needles to inject drugs? No Yes

Do you exercise? What exercise activities do you engage in? _____

Are you? Married _____ Divorced _____ Single _____ In a Supportive Relationship _____

Do you currently live with? Spouse _____ Partner _____ Friends _____ Children _____ Alone _____

What is your current level of education? _____ Are you satisfied with this? Y N

What is your occupation? _____ Do you have job satisfaction? Y N

Do you have children? Y N How many? _____ Ages? _____

Do your children have any health concerns? _____

Do you have a spiritual practice? _____ Are you happy with it? Y N

Diet: Diet: How do you rate your diet? Good Fair Poor

What is a typical day of food/drinks for you?

Breakfast _____ Lunch _____ Dinner _____ Snacks _____

How much water do you consume in the average day? _____

Review of Systems: Please circle if you have had or are presently experiencing any of the following:

REVIEW OF SYSTEMS: Please **circle Yes or No** to indicate if **you** currently have any problems in one or more of the following areas? If yes, please explain or describe the problem.

GENERAL / CONSTITUTIONAL Yes / No
(fever, weight loss or gain, tired feeling) _____

EYES Yes / No
(blurred vision, eye pain, discharge, etc.) _____

EARS, NOSE, THROAT, MOUTH Yes / No
(hearing loss, ear ache, nasal congestion, chronic cough, nasal drip, dry mouth, allergies, hay fever, etc.) _____

RESPIRATORY Yes / No
(asthma, emphysema, chronic bronchitis, wheezing, shortness of breath, etc.) _____

CARDIOVASCULAR Yes / No
(diabetes, hypertension, heart problems) _____

GASTROINTESTINAL Yes / No
(diarrhea, constipation, hernia, ulcers, etc.) _____

GENITOURINARY Yes / No
(painful urination, frequent urination, impotence, jaundice, etc.) _____

LYMPHATIC Yes / No
(anemia, bleeding problems, problems with blood transfusions, etc.) _____

MUSCULOSKELETAL Yes / No
(arthritis, joint pain, muscle pain, cramps, stiffness, swelling, etc.) _____

SKIN Yes / No
(pimples, warts, growths, rashes, etc.) _____

Other: _____

What is your weakest organ system and why? _____

Female Reproductive/Gynecological/Obstetrical History

Age of first menses: _____ If periods have stopped, at what age did they stop? _____

Are your cycles regular? Y N Period begins every _____ days Lasting _____ days

Are your periods? Heavy/Medium/Light What color is the blood? Light/Dark, Medium Red/Clots

Do you have any spotting or bleeding in between periods? Y N Any cramps with period? Y N

Circle any premenstrual symptoms:

Water Retention Breast Tenderness Irritability Headaches Depression Mood Swings

Food Cravings Other _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Any problems getting pregnant? _____

Do you get yearly PAP smears? Y N Do you perform monthly Self-Breast Exams? Y N

Are you currently sexually active? _____ How often? _____ Is this more or less than 1 year ago? _____

Have you been tested for sexually transmitted diseases? Y N When? _____

Are you currently using birth control? _____ What type(s)? _____

Do you experience any of the following:

Prolonged or abnormal bleeding: No Yes Please describe: _____

Leakage of urine: No Yes Please describe: _____

Pelvic pain: No Yes Please describe: _____

Abnormal discharge: No Yes Please describe: _____

History of abnormal Pap smear: No Yes Type of treatment: _____

History of abnormal Breast Exam: No Yes Please describe: _____

Have you ever been physically, sexually, emotionally or verbally abused? Y N

How old and how often? _____

Other: _____

Male Reproductive

How often do you have to get up at night to urinate? _____

Is this more than a few years ago? Y N

Are you currently sexually active? _____ How often? _____ Is this more or less than 1 year ago? _____

Have you been tested for sexually transmitted diseases? Y N When? _____

Any history of sexually transmitted disease(s)? Y N If yes, what was the treatment? _____

Any abnormal discharge from penis? Y N Sores on penis or groin? _____

Are you currently using protection during intercourse? _____ What type(s)? _____

Any Problems with impotency (getting or maintaining an erection)? Y N

Do you currently have, or have a history of prostate problems? (please describe) _____

Date of last prostate exam? _____ Abnormal findings? Y N, please describe _____

PSA? _____ Other pertinent information: _____

Have you ever been physically, sexually, emotionally or verbally abused? Y N How old and how often?

Other: _____

Digestion and Elimination

Do you have any problems with gas, bloating or fullness after eating? Y N

How often (please circle)? Often/ Sometimes/ Never How severe? _____

Gas in Upper/Lower Abdomen or Both/Neither? How long have you had this problem? _____

Current Bowel movement frequency: _____ Is this typical for you? _____

Do you ever have (please circle) Blood/ Mucus/ Undigested Food/ Floating stool/ Black stool?

Any rectal itching? Y N Do your stools tend to be (please circle): Formed / Loose / Alternating

How often do you have diarrhea? _____ constipation? _____

Do you ever have alternating constipation & diarrhea? Y N

How would you describe the color of your stool (please circle)?

Yellow / Brown / White / Dark / Black / Green Other: _____

How often do your stools have a strong disagreeable odor? Often Sometimes Never

Have you traveled outside the US in the past 5 years? Y N Where? _____

Have you gone camping in the last 5 years? Y N Where? _____

Kidneys and Bladder

Have you had recurrent bladder infections? Y N How were they treated? _____

How many bladder infections have you had in the past 3 years? _____

Do you have any burning sensation during or after urinations? (past or present)

Do you have difficulty starting or stopping when urinating? Y N

Does your urine have a strong odor to it? Y N

Do you have difficulty perspiring? Y N Do you perspire during exercise? Light/Medium/Heavy

Do you perspire other times than when exercising? Y N When? _____

Does your perspiration have a strong smell? _____

Occupational/Household/Environmental Exposures

How long have you lived at your present address? _____ What state did you previously live in? _____

Please describe current location, if old or new place, i.e. new construction, damp or moldy, near power lines or industrial buildings, etc. _____

New Carpet or flooring? _____ Recent painting or remodeling? _____

Do you have specialized air filtration in home? Y N Do you live in the city? Y N

Do you work in an office building? Y N Do the windows open? Y N

Do you have specialized filtration in your work place? Y N

Do you work in the presence of toxic fumes or chemicals? Y N

Do any of your hobbies involve toxic materials? Y N

Are you exposed to second hand smoke currently? Y N

What do you use for your drinking water (please circle)? Bottled Filtered Tap

Regarding environmental exposures, do you have anything else you would like to comment on?

Thank You.

Lets Start Your Journey Towards Better Health.