

## One Sky Wellness Associates Health History

6300 9th Ave NE, Suite 300, Seattle WA 98115 (206) 363-5555 fax (206) 363-5533 <http://oneskywellness.com>

~This information will be contained in your confidential medical history~

Please print

Name(first, middle, last)	Birthday	Today's date
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Main Concern or reason(s) for seeing the Doctor:

### Past History

Major Illnesses (please give names and dates):	Previous Hospitalizations or Surgeries:
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### Well Being

Goals for Health

What practices or activities do you use to sustain your health and well being? (religious, spiritual/what inspires you?)

Who do you turn to for support?	What causes stress for you?
Who lives in your home?	

### Nutrition/Food Habits: Describe/Summarize

**Smoking:** Packs per day \_\_\_\_\_ Number of years \_\_\_\_\_  
 Years Stopped \_\_\_\_\_ Pipe Cigar Chew \_\_\_\_\_

**Alcohol:** Never Occasional Moderate Heavy Alcohol Problem? Y N How much per week? \_\_\_\_\_

**Exercise:** Never Occasional Moderate Heavy What Kind? \_\_\_\_\_ How often? \_\_\_\_\_

**Caffeine:** Coffee: \_\_\_\_\_ cups per day Tea: \_\_\_\_\_ cups per day Coke/Pepsi, ect. \_\_\_\_\_ cans/week

**Sleep:** Well Rested \_\_\_\_\_ Restless \_\_\_\_\_ <8hrs/night \_\_\_\_\_ 5-8hrs/night \_\_\_\_\_ >8hrs/night \_\_\_\_\_

**Diet:** Servings per day: Meat \_\_\_\_\_ Fruit \_\_\_\_\_ Vegetables \_\_\_\_\_  
 Fish \_\_\_\_\_ Sweets \_\_\_\_\_ Fiber \_\_\_\_\_

**Water:** Servings per day: \_\_\_\_\_ Filtered: \_\_\_\_\_ Tap: \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Weight at age 20:** \_\_\_\_\_ **Weight change last year:** gain \_\_\_\_\_ lbs lost \_\_\_\_\_ lbs

**OCCUPATIONAL EXPOSURES:** \_\_\_\_\_ Asbestos \_\_\_\_\_ Other(describe) \_\_\_\_\_

Medication/Supplement	Dose	Frequency	Start Date

Allergies/Drug Allergies

## One Sky Wellness Associates Health History

*SYSTEM REVIEW: Check if you have any symptoms or problems to any important or significant degree.*

<input type="checkbox"/> Tired all the time	<input type="checkbox"/> Frequent chest colds	<input type="checkbox"/> Arthritis/joint pain	<input type="checkbox"/> Difficulty with urine	<input type="checkbox"/> Kidney stone
<input type="checkbox"/> Don't feel well	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Gout	<input type="checkbox"/> Protein/blood in urine	<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Weakness	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Yellow Jaundice	<input type="checkbox"/> Skin rash
<input type="checkbox"/> Weight problem	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Back pain or trouble	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Skin trouble
<input type="checkbox"/> Fluid retention	<input type="checkbox"/> Asthma/wheezing	<input type="checkbox"/> Bursitis/tendonitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Food avoidance
<input type="checkbox"/> Lack of exercise	<input type="checkbox"/> Hayfever	<input type="checkbox"/> Swallowing trouble	<input type="checkbox"/> Food intolerance	<input type="checkbox"/> Bleed or bruise easily
<input type="checkbox"/> Headache	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Nervous	<input type="checkbox"/> Anemia
<input type="checkbox"/> Migraine	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Tense/irritable	<input type="checkbox"/> Infertility problem
<input type="checkbox"/> Fainting	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Nervous stomach	<input type="checkbox"/> Bored	<input type="checkbox"/> Sexual difficulty
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Depressed	
<input type="checkbox"/> Epilepsy/seizure	<input type="checkbox"/> Heart palpation/racing	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Trouble sleeping	
<input type="checkbox"/> Ear/hearing problem	<input type="checkbox"/> Chest tightness/pressure	<input type="checkbox"/> Black/bloody stools	<input type="checkbox"/> Relationship problems	Date of last Physical:
<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Angina	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Job problems	Date of last Dental exam:
<input type="checkbox"/> Stuffy nose	<input type="checkbox"/> Blood disease	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Personal problems	Date of last eye exam:
<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Enlarged heart	<input type="checkbox"/> Spastic colon	<input type="checkbox"/> Nervous breakdown	Date of last blood work:
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Colitis	<input type="checkbox"/> Psychiatrist seen	Date of last tetanus shot:
<input type="checkbox"/> Persistent hoarseness	<input type="checkbox"/> Leg pain on walking	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> High blood sugar	Immunizations:
<input type="checkbox"/> Glasses	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hypoglycemia	Hep B?            Date:
<input type="checkbox"/> Vision/eye trouble	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Thyroid trouble	Hep A?            Date:
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Ankle/leg swelling	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Bladder problems	Varicella/chicken pox vaccine:
<input type="checkbox"/> Cataract	<input type="checkbox"/> Allergies(not hayfever)	<input type="checkbox"/> Gall bladder trouble	<input type="checkbox"/> Kidney infection	

MEN ONLY	WOMEN ONLY	
<input type="checkbox"/> Discharge from penis	Age menstruation began:	Last menstrual period date:
<input type="checkbox"/> Prostate trouble	Periods:    Regular    Irregular	Vaginal Discharge?
<input type="checkbox"/> Stream weak or slow	Hot flashes?    Yes    No	IUD?    Yes    No
<input type="checkbox"/> Swelling or pain in testes	Breast lump or discharge?    Yes    No	Year IUD inserted:
DATE of Vesectomy:	Number of Pregnancies:	Type of birthcontrol:
	Number of Abortions:	Date of last pap smear:
	Number of Miscarriages:	Date of last mammogram:
	Please list pregnancy dates and outcomes:	

### FAMILY HISTORY: (check at left and list family members at right)

<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Trouble	
<input type="checkbox"/> Heart attack	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Alcoholism	
<input type="checkbox"/> Cancer (kind?)	
<input type="checkbox"/> Autoimmune, Arthritis ect.	
<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Other...	