Helios Integrated Medicine 4150 Darley Ave #1 Boulder, CO 80305, 303-499-9224

Health History---

Name__________________________________ Date ___/___/___ Age_______ M / F
Married___ Separated___ Divorced___ Widowed___ Single___ Education___________
Occupation__________________ Years worked______ Hours worked in a week_______
Who lives in your house?____

Do you see other health care practitioners? For what problems?____
____
____

Hospitalizations: Please indicate any major hospitalizations you have had for serious injuries, illnesses, or operations.

Year	Reason	How long in hospital

Illnesses: Please indicate whether you have ever had, or currently have any of the following illnesses or symptoms:

Ever	Now		Ever	Now		Ever	Now	
___	___	Allergies	___	___	Glaucoma	___	___	Alcoholism
___	___	Asthma	___	___	Rheumatic Fever	___	___	Addictions
___	___	Eczema	___	___	Hives/Rashes	___	___	Tuberculosis
___	___	Anemia	___	___	Hernia	___	___	High Cholesterol
___	___	Phlebitis	___	___	Hemorrhoids	___	___	Liver Disease
___	___	Excessive Bleeding	___	___	Stroke	___	___	Venereal Disease
___	___	Heart Disease	___	___	Yellow Jaundice	___	___	Sexual Difficulties
___	___	Hepatitis	___	___	Ulcer	___	___	Nervousness
___	___	Epilepsy	___	___	Herpes	___	___	Weight loss/gain
___	___	Recurrent Infection	___	___	Diabetes	___	___	Insomnia
___	___	Depression	___	___	Fatigue	___	___	Sleep Apnea
___	___	Cancer or Tumor	___	___	Heart Murmur	___	___	Thyroid Disease
___	___	Pancreatitis	___	___	Stomach Problems	___	___	Prostate Infection
___	___	Enlarged Prostate	___	___	Hypertension	___	___	Traumatic Injuries
___	___	Serious Cuts	___	___	Bladder Problems	___	___	Kidney Problems
___	___	Suicide Attempts/Thoughts						

Family History: Please complete health information below for each member of your family.

	In Good Health	In Poor Health	Deceased	Cause of Death & age	Stroke	AllergiesAsthma/	Alcoholism	EasilyBleed	Diabetes	Epilepsy	TumorCancer/	Arthritis	Depression	Anxiety	Anemia	Heart Trouble	High Cholesterol	High Blood Pressure	Kidney/Bladder Trouble	Stomach Trouble
Father																				
Mother																				
Siblings																				
Maternal Grandmother																				
Maternal Grandfather																				
Paternal Grandmother																				
Paternal Grandfather																				
Spouse																				
Children																				

What medications, including non-prescription drugs, birth control pills, etc., do you take?

_________________________ _________________________
_________________________ _________________________
_________________________ _________________________
_________________________ _________________________
_________________________ _________________________

Please indicate any significant allergies or reaction to medications, foods, plants, animals, chemicals, etc.

Substance Reaction Substance Reaction

_______________________________ _______________________________
_______________________________ _______________________________

Health Habits:

Yes No
___ ___ Do you wear a seatbelt?
___ ___ Have you had an HIV antibody test? Date:______
___ ___ Are you sexually active? Preference (circle one): Male Female
___ ___ Are you happy with your weight?
___ ___ Have you traveled outside of the United States? If your answer is yes, when and where?

Date Location

____
____
____

Do you follow any special diet? If yes, please describe:

____
____
____
___

How much, and in what form, do you consume the following?

Snack foods/refined sugar____

Tobacco________________________________ Alcohol________________________________

Caffeine___________________________ “Recreational Drugs”__________________________

What do you do for exercise and how often?____

What do you do for relaxation or meditation____

Please list any toxic substances at work for home that you’ve been exposed to:

___Mold
___ Construction Debris
___ Pets
___ Heavy Metals
___ Chemicals
___ Exhaust
___ Fumes

For women Only:

Date of last menstrual period:________ Average number of days in between periods_____

How many days your period last?_______

Age when you started your period_____ Age when menopause started______

Date of your last female exam_________ Date of last pap smear______

Yes	No	
___	___	Do you have PMS symptoms? If yes, please describe: _________________________
___	___	Do you have recurrent yeast infections?
___	___	Do you use birth control? Type?__________________ For how long?___________
___	___	Are you satisfied with your birth control method?
___	___	Do you perform self breast exams regularly?
___	___	Have you ever been pregnant? Number of pregnancies____ Miscarriages____ Abortions____ Living Children_____
___	___	Have you ever had an abnormal pap smear? Date _______
___	___	Have you ever had a pelvic infection?
___	___	Do you have pain or problems with intercourse?
___	___	Did your mother take the hormone DES during pregnancy?

For men only:

___Yes ___ No Do you perform self-testicular exams?