NAME: _____ **DOB:** _____

Evolutionary Medicine LLC

Medical History

Height: _____ Weight: _____ Blood Pressure: _____

Current Health Care Practitioners *(name, type)*: _____

_____

_____

Past Disease Diagnoses *(diagnosis, year, outcome)*:
Hospitalizations of past 5 years *(reason, year, length)*:
Surgeries (*type, year, outcome)*:
Medications *(name, dose, month/year started)*:
Supplements *(name, dose)*:

Trauma / Accident History:

Motor Vehicle Accidents	□ Y □ N	Dates: _____ _____ _____
Concussions	□ Y □ N	Dates: _____ _____ _____
Broken Bones	□ Y □ N	Dates: _____ _____ _____
Significant Falls	□ Y □ N	Dates: _____ _____ _____
Other	□ Y □ N	What / When: _____

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Allergies

Seasonal: □ Y □ N Type: _____

Food: □ Y □ N Type: _____

Other: □ Y □ N Type: _____

Lifestyle

Home: Enjoy? Y N Live with: _____ Pets: _____

Partner: Relationship? Y N Happy? Y N Years Together / Since: _____

Work: Rewarding? Y N Company / Position: _____ Hours per week: _____

Sleep: Wake Rested? Y N Hours per night: _____ Insomnia? Y N Apnea? Y N

Exercise: Routinely? Y N Types: _____ Frequency: _____

Habits: Water Consumption: _____oz per day Soda Consumption: _____oz per day

Caffeine? Y N Type: _____ Drinks (espresso shots) per Day: _____

Alcohol? Y N Drinks per Week: _____ 3+ Drinks / Day? Y N Times per week: _____

Tobacco? Y N Quantity per Day: _____ Year Start: _____ Year Quit: _____

Marijuana? Y N Quantity per Week: _____ Year Start: _____ Year Quit: _____

Other Drugs? Y N Types: _____ Frequency: _____

Hobbies: _____

Stress Level *(1 to 10 max)*: _____ Cause: _____

Stress Management Techniques: _____

Support System / Community: _____

Spiritual Life: Y N Explain: _____

Overall Health *(1 to 10 excellent)*: _____ *(circle)*: Improving Staying Same Declining

Energy Level *(1 to 10 excellent)*: _____ *(circle)*: Improving Staying Same Declining

Mental Illness History? Y N Explain: _____

Family Health History

	Alive?	Age (at death)	Disease History
Paternal Grandmother	Y N		
Paternal Grandfather	Y N		
Maternal Grandmother	Y N		
Maternal Grandfather	Y N		
Father	Y N		
Mother	Y N		
Sibling □ M □ F	Y N		
Sibling □ M □ F	Y N		
Sibling □ M □ F	Y N		

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C= Current P=Past

Musculoskeletal:

	C	P
Joint Pain / Stiffness	C	P
Where: _____		
Low Back Pain	C	P
Neck /Shoulder Pain	C	P
Carpal Tunnel Syndrome	C	P
Osteoarthritis	C	P
Rheumatoid Arthritis	C	P
Muscle Spasms	C	P
Muscle Weakness	C	P
Sprains / Strains	C	P
Broken Bones	C	P
Osteoporosis	C	P

Skin:

Rashes	C	P
Eczema or Hives	C	P
Dry Skin	C	P
Night Sweats	C	P

Eyes:

Glasses / Contacts	C	P
Blurry Vision	C	P
Double Vision	C	P
Floaters	C	P
Eye Pain	C	P
Tearing / Dryness	C	P

Ear / Nose / Throat:

Allergies	C	P
Stuffiness	C	P
Frequent colds	C	P
Sinus infections	C	P
Nose bleeds	C	P
Sore Throat	C	P
Swollen Tongue	C	P
Difficulty swallowing	C	P
Neck Lumps	C	P
Loss of Hearing	C	P
Ear Ringing	C	P
Earache	C	P

Respiratory:

Wheezing	C	P
Frequent Cough	C	P
Shortness of Breath	C	P
Pain on Breathing	C	P
Asthma	C	P
Bronchitis	C	P
Pneumonia	C	P
Emphysema	C	P

Cardiovascular:

Fluttering in Chest	C	P
Chest Pain / Angina	C	P
High Blood Pressure	C	P
Heart Attack	C	P
Heart Failure	C	P
Heart Murmur	C	P
High Cholesterol	C	P
Ankle Swelling	C	P

Peripheral vascular:

Bleeding or Bruising	C	P
Anemia	C	P
Cold Hands & Feet	C	P
Raynauds Disease	C	P
Varicose Veins	C	P
Deep Vein Thrombosis	C	P

Gastrointestinal:

Indigestion	C	P
Heartburn	C	P
Nausea	C	P
Vomiting	C	P
Stomach Ulcer	C	P
Abdominal Pain	C	P
Liver Disease	C	P
Hemorrhoids	C	P
Constipation	C	P
Diarrhea	C	P
BM Frequency _____ per week		

Urinary:

Frequent Urination	C	P
Dribbling Urine	C	P
Incontinence	C	P
Urinary Tract Infx	C	P
Pain on Urination	C	P
Kidney Stones	C	P

Neurological:

Numbness/Tingling	C	P
Headaches	C	P
Migraines	C	P
Stroke	C	P
Seizures	C	P
Loss of Coordination	C	P
Loss of Balance	C	P
Fainting	C	P
Paralysis	C	P
Memory Loss	C	P
Loss of Taste / Smell	C	P

Endocrine:

Excessive Thirst	C	P
Hyperthyroid	C	P
Hypothyroid	C	P
Heat Intolerance	C	P
Cold Intolerance	C	P
Adrenal Fatigue	C	P
Diabetes	C	P

Emotional:

Depression / Sadness	C	P
Anxiety	C	P
Mood Swings	C	P
Anorexia / Bulemia	C	P

Cancer: C P

Type: _____

Stage: _____

Current Treatment: Y N

Sexual:

Sexually Active	C	P
Low Libido	C	P
Venereal Diseases	C	P
Diagnosed: _____		

Male Reproductive:

Hernia	C	P
Impotence	C	P
Enlarged Prostate	C	P
Date of Last Exam: _____		

Female Reproductive:

Age at Menarche _____ years		
Avg Cycle Length _____ days		
> 30 Day Cycle	C	P
< 27 Day Cycle	C	P
Intermenstrual Blood	C	P
Menstrual Cramps	C	P
Blood Clots	C	P
Vaginal Infections	C	P
Pain with Intercourse	C	P
Birth Control	C	P
Birth Control	C	P

Last Pap Smear Date: _____

Date of Last Menses: _____

No. of Pregnancies _____

No. of Abortions _____

No. of Miscarriages _____

No. of Live Births _____