

# NORTHWESTERN ACADEMY OF HOMEOPATHY

## HEALTH INVENTORY

[THIS INFORMATION IS CONFIDENTIAL AND WILL ONLY BE RELEASED WITH YOUR SIGNED CONSENT]

Name \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

Today's date \_\_\_\_\_

Address \_\_\_\_\_  
COUNTY

Birthdate \_\_\_\_\_

\_\_\_\_\_  
CITY STATE ZIP

Age \_\_\_\_ Sex \_\_\_\_ Height \_\_\_\_ Weight \_\_\_\_

Phone: WORK: \_\_\_\_\_ HOME: \_\_\_\_\_

Legal status: S M D Sep W

Emergency contact: Name: \_\_\_\_\_

Education (yrs. completed):

Phone #: \_\_\_\_\_ Relationship \_\_\_\_\_

Elem \_\_\_\_ HS \_\_\_\_ Coll \_\_\_\_ Voc \_\_\_\_ Prof \_\_\_\_

If under 18, parents' name/address \_\_\_\_\_

Occupation \_\_\_\_\_

Referred by \_\_\_\_\_

Retired:  Yes  No

Address \_\_\_\_\_

Family Physician \_\_\_\_\_

Address \_\_\_\_\_

### FAMILY HISTORY

Check if family history is unknown.

	Age	If deceased, cause of death
<b>Father</b>		
<b>Mother</b>		
<b>Siblings</b>		

Children	Age	Problems

Check items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles).

- | YES   | RELATIONSHIP |
|---|--------------|
| <input type="checkbox"/> Alcohol/drug problem         | _____        |
| <input type="checkbox"/> Allergy/asthma               | _____        |
| <input type="checkbox"/> Anemia                       | _____        |
| <input type="checkbox"/> Arteriosclerosis             | _____        |
| <input type="checkbox"/> Arthritis                    | _____        |
| <input type="checkbox"/> Binge eating/bulimia         | _____        |
| <input type="checkbox"/> Bleeding problem             | _____        |
| <input type="checkbox"/> Cancer                       | _____        |
| <input type="checkbox"/> Diabetes                     | _____        |
| <input type="checkbox"/> Epilepsy/seizure             | _____        |
| <input type="checkbox"/> Heart disease                | _____        |
| <input type="checkbox"/> Skin disease                 | _____        |
| <input type="checkbox"/> Endocrine/hormonal imbalance | _____        |

- | YES  | RELATIONSHIP |
|--|--------------|
| <input type="checkbox"/> High blood pressure       | _____        |
| <input type="checkbox"/> High cholesterol/fat      | _____        |
| <input type="checkbox"/> Kidney disease            | _____        |
| <input type="checkbox"/> Liver disease             | _____        |
| <input type="checkbox"/> Mental illness            | _____        |
| <input type="checkbox"/> Obesity                   | _____        |
| <input type="checkbox"/> Stroke                    | _____        |
| <input type="checkbox"/> Suicide                   | _____        |
| <input type="checkbox"/> Thyroid disease           | _____        |
| <input type="checkbox"/> Tuberculosis              | _____        |
| <input type="checkbox"/> Gastro intestinal disease | _____        |
| <input type="checkbox"/> Syphilis                  | _____        |
| <input type="checkbox"/> Gonorrhea                 | _____        |

## PAST HISTORY OF ILLNESS AND MEDICAL PROBLEMS

Surgery: List all surgery and approximate dates

Other hospitalizations and dates

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Broken bones and/or traumatic injuries  
(include all car accidents or concussions)

Current health problems  
*Example: High blood pressure - 10 yrs.*

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### PAST HISTORY

YES	WHEN	YES	WHEN	YES	WHEN
<input type="checkbox"/> Acne	_____	<input type="checkbox"/> Epstein Barr/ infectious mono	_____	<input type="checkbox"/> Periodontal disease	_____
<input type="checkbox"/> AIDS	_____	<input type="checkbox"/> Fibrocystic breasts	_____	<input type="checkbox"/> Phlebitis	_____
<input type="checkbox"/> Alcohol/drug problem	_____	<input type="checkbox"/> Fibroids	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Gallbladder problem	_____	<input type="checkbox"/> Premenstrual tension	_____
<input type="checkbox"/> Amalgams/silver fillings	_____	<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Prostate problem	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Gonorrhea	_____	<input type="checkbox"/> Psychotherapy	_____
<input type="checkbox"/> Antibiotics more than once a year	_____	<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Reactions to vaccinations	_____
<input type="checkbox"/> Anorexia	_____	<input type="checkbox"/> Hay fever	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> Hearing problem	_____	<input type="checkbox"/> Root canal	_____
<input type="checkbox"/> Arteriosclerosis	_____	<input type="checkbox"/> Heart attack	_____	<input type="checkbox"/> Scarlet fever	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Heart failure	_____	<input type="checkbox"/> Sexually transmitted disease	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Heart problem	_____	<input type="checkbox"/> Sinusitis	_____
<input type="checkbox"/> Back pain/strain	_____	<input type="checkbox"/> Hemorrhoids	_____	<input type="checkbox"/> Skin problem	_____
<input type="checkbox"/> Binge eating	_____	<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Sleep disorder	_____
<input type="checkbox"/> Bladder infection	_____	<input type="checkbox"/> Herpes	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Blood clots	_____	<input type="checkbox"/> Hiatal Hernia	_____	<input type="checkbox"/> Suicide attempt	_____
<input type="checkbox"/> Breast lump	_____	<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Syphilis	_____
<input type="checkbox"/> Bronchitis	_____	<input type="checkbox"/> High cholesterol/ triglycerides	_____	<input type="checkbox"/> Taken steroid (cortisone/prednisone)	_____
<input type="checkbox"/> Bulimia (self-induced vomiting)	_____	<input type="checkbox"/> Hives	_____	<input type="checkbox"/> Thyroid problem	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Hypoglycemia	_____	<input type="checkbox"/> Tonsillitis	_____
<input type="checkbox"/> Cataract	_____	<input type="checkbox"/> Insomnia	_____	<input type="checkbox"/> Tooth problems	_____
<input type="checkbox"/> Chemical sensitivity	_____	<input type="checkbox"/> Kidney infection	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Chicken pox	_____	<input type="checkbox"/> Kidney stones	_____	<input type="checkbox"/> Urine problem	_____
<input type="checkbox"/> Chronic fatigue	_____	<input type="checkbox"/> Kidney problem	_____	<input type="checkbox"/> Vaginitis	_____
<input type="checkbox"/> Colds, frequent	_____	<input type="checkbox"/> Liver disease	_____	<input type="checkbox"/> Vision problem	_____
<input type="checkbox"/> Colitis	_____	<input type="checkbox"/> Menstrual problem	_____	<input type="checkbox"/> Warts	_____
<input type="checkbox"/> Congenital defect	_____	<input type="checkbox"/> Mental illness	_____	<input type="checkbox"/> Other problems	_____
<input type="checkbox"/> Counseling	_____	<input type="checkbox"/> Migraine	_____	_____	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Nervous condition	_____	_____	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Neurologic problem	_____	_____	_____
<input type="checkbox"/> Ear infection	_____	<input type="checkbox"/> Neurologic problem	_____	_____	_____
<input type="checkbox"/> Eczema	_____	<input type="checkbox"/> Overweight (20 lbs)	_____	_____	_____
<input type="checkbox"/> Endometriosis	_____	<input type="checkbox"/> Panic Attacks	_____	_____	_____
<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Pelvic infection	_____	_____	_____
		<input type="checkbox"/> Peptic ulcer	_____	_____	_____

## REVIEW OF SYSTEMS

Answer "yes" if you have had these symptoms *in the last 6 months*.

### YES

- Chronic fatigue
- Mood swings
- Chronic depression
- Trembling episodes
- Light-headedness
- Food craving
- Frequent infection
- Night sweats
- Swollen glands
- Skin rash
- Chills/fever
- Change in skin/nails
- Change in wart or mole
- Abnormal bleeding/bruising
- Change in hair loss/growth
- Irritability
- Restlessness
- Headaches
- Dizziness
- Balance problem
- Head injury
- Seizure/convulsion
- Poor memory
- Difficulty concentrating
- Fainting
- Weakness
- Numbness/tingling
- Blurred vision
- Double vision
- Loss of any vision
- Halos around lights
- Excessive tearing/itching
- Eye pain
- Dark circles under eyes
- Date last eye exam \_\_\_\_\_
- Loss of hearing
- Ringing/buzzing in ears
- Sinus trouble
- Nosebleed
- Sore throat
- Hoarseness
- Change in voice
- Dental problem
- Dry mouth
- Excessive salivation
- Bleeding gums
- Mouth breather

### YES

- Chronic cough
- Bloody/yellow sputum
- Shortness of breath
  - with exertion
  - at night
- Bronchitis
- Chest pain with breathing
- High blood pressure
- Chest pain or pressure
  - at rest
  - with exertion
  - with stress
  - with eating
  - down left arm, neck or back
  - accompanied by nausea, sweating, anxiety
- Irregular heartbeat
- Skip beats
- Palpitations
- Fast heart beat
- Heart murmur
- Swelling feet/legs
- Cold hands/feet
- Leg cramps at night
- Joint pain
- Pain or fatigue in legs with exercise
- Burning feet
- Sore legs/feet
- Color change legs/arms
- Difficulty swallowing
- Pain/discomfort when eating
- Bad teeth
- Belching
- Coating on tongue
- Canker sores
- Pain relieved by eating
- Nausea/vomiting
- Trouble with fried foods
- Bloating of abdomen
- Bowel gas
- Diarrhea
- Constipation
- Black stool
- Clay-colored stool
- Mucus in stool
- Hemorrhoids
- Rectal bleeding

### YES

- Abdominal pain
- Change in diet
- Pain/burning urination
- Frequent urination
- Urination at night
- Blood in urine
- Foul odor to urine
- Low back pain
- Loss of control of urine

### MEN

- Enlarged prostate
- Decreased urine stream
- Unable to interrupt stream
- Dribbling after urination
- Pus or drainage from penis
- Genital swelling/rash
- Problem with sexual function

### WOMEN

- Last menstruation period \_\_\_\_\_
- Age menstruation began \_\_\_\_\_
- Age at menopause \_\_\_\_\_
- Number of pregnancies \_\_\_\_\_
- Number of live births \_\_\_\_\_
- Number of abortions/miscarriages \_\_\_\_\_
- Complication of pregnancy
- Used birth control pills
- Used IUD  
type: \_\_\_\_\_
- Usual length of cycle \_\_\_\_\_
- Usual length of period \_\_\_\_\_
- Change in cycle
- Spotting between periods
- Discomfort with periods
- Premenstrual tension
- Vaginal discharge
- Painful intercourse
- Itching
- Self breast examination
- Problem w/sexual function
- Lump in breast
- Abnormal pap smear
- Infertility
- Date of last pap smear \_\_\_\_\_

Please turn page.

# PERSONAL HISTORY

## Current medications

List all prescriptions and non-prescriptions including dosage

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## Vitamin and mineral supplements

Type and dosage

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## Allergies

I am allergic to the following medications:

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## Food allergies and method of testing

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## Lifestyle

List your favorite foods or cravings

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I find my work  too demanding  boring  satisfactory  
 very satisfying.

My sex life is satisfactory.  yes  no

I do the following for relaxation/recreation: \_\_\_\_\_

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I am now or have been a smoker.  yes  no

How many years have you smoked? \_\_\_\_\_

How much? \_\_\_\_\_

When did you quit? \_\_\_\_\_

I estimate my use of:

coffee: \_\_\_\_\_ cups/day      decaf: \_\_\_\_\_ cups/day

I use  beer  wine  "hard" liquor.

I consider myself a  non-drinker  social drinker  
 heavy drinker  alcoholic  recovering alcoholic

I use  marijuana  other drugs \_\_\_\_\_

I have participated in an exercise program.  yes  no

I exercise on a regular basis.  yes  no  
\_\_\_\_\_ Times \_\_\_\_\_ Week/Month

I think this is enough exercise.  yes  no

I would like to do more exercise.  yes  no

I sleep well.  yes  no

I worry about  money  job  family life  
 relationships  other \_\_\_\_\_

I currently see a psychotherapist or other mental health professional.  yes  no

I have had a therapeutic massage.  yes  no

I currently see a chiropractor, osteopath, or other physical therapy person.  yes  no

I have been arrested.  yes  no

I have been in the military service.  yes  no

I have been a victim of abuse.  physical  sexual  
 emotional

My spiritual life is satisfactory.  yes  no

I am currently involved in a regular spiritual program  
 yes  no

My last physical exam was \_\_\_\_\_