1. Medication History

List medications you are allergic to:

Name	Known Reaction
Example: Antibiotics	Hives
1.	
2.	
3.	

How often have you taken antibiotics?

	Less than 5 times	More than 5 times	Purpose	Any complications?
Infancy/Childhood				
Teenager				
Adulthood				

List ALL medications taken in the PAST and PRESENT.

Medication	Reason for Taking	Year Started	Year Stopped	Dose
Example: Lexapro	Anxiety	2008	Still taking	20mg
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				

Are you interested in improving your health to reduce your need for medication? ❑ Yes ❑ No

Do you fully understand you must work with your prescribing physician for any dosage adjustment to any prescribed medication? ❑ Yes ❑ No

Prescribing Physician Name: _____ Phone: _____

2. Surgery History

Check off (√) which surgeries you have had:

❑ Spleen removal
❑ Gallbladder removal
❑ Tonsil removal
❑ Thyroid removal
❑ Colorectal resection
❑ Appendix removal
❑ Hernia
❑ C-Section
❑ Hysterectomy (Full)
❑ Hysterectomy (Partial)
❑ Implants/Prosthesis
❑ Plastic Surgery
❑ Fibroid Removal
❑ Liver lobe removal
❑ Hip Replacement
❑ Knee Replacement
❑ Spinal Fusion
❑ Cataract removal
❑ Eye Correction
❑ Biopsy (List where in next section)
❑ Other(List where in next section)
❑ Circumcision
❑ Angioplasty or Atherectomy
❑ Heart Bypass Surgery
❑ Pacemaker installation
❑ Stent Procedure

For each surgery you have had, provide additional info below:

Surgery	Year Performed	Reason for surgery	Any complications afterward?
Example: Appendix Removal	2006	Ruptured	Pain and scar tissue still present
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

3. Hospitalizations

List ALL non-surgery related hospitalizations you have had (minor to serious).

Where Hospitalized	Year of Occurrence	Reason for hospitalization
Example: Kaiser - Walnut Creek	2005	Fainted & hit head on coffee table
1.		
2.		
3.		
4.		
5.		

4. Vaccine-Injury or vaccine side effects

Have you experienced any known adverse reactions due to a vaccine? For example, seizure, rash, eczema, peanut allergy, latex allergy, loss of speech, Guillain Barre, Diabetes, ovarian failure, etc.):

❑ Yes ❑ No Describe: _____

Were you breast-fed as a child: ❑ Yes ❑ No ❑ Unsure

5. Family Health History

Please check off any condition that a member of your family has experienced.

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcohol/Drug Abuse	❑	❑	❑	❑	❑	❑	❑	❑	❑
Allergies/Sinus	❑	❑	❑	❑	❑	❑	❑	❑	❑
Anemia/Blood Disorder	❑	❑	❑	❑	❑	❑	❑	❑	❑
Arthritis	❑	❑	❑	❑	❑	❑	❑	❑	❑
Birth Defect	❑	❑	❑	❑	❑	❑	❑	❑	❑
Cancer/Type	❑	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑	❑
Depression/Anxiety	❑	❑	❑	❑	❑	❑	❑	❑	❑
Mental Health Disorder	❑	❑	❑	❑	❑	❑	❑	❑	❑
High Cholesterol	❑	❑	❑	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑	❑	❑
Obesity	❑	❑	❑	❑	❑	❑	❑	❑	❑
Thyroid Disorder	❑	❑	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑	❑	❑

6. Supplement History

List supplements, minerals, or vitamins you are allergic to.

Name	Known Reaction
Example: Iodine	Eczema, rash
1.	
2.	
3.	

List ALL supplements you are CURRENTLY taking.

Supplement	Reason for Taking	Year Started
Example: Centrum Jr. (synthetic)	Prenatal	2014
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

7. Food History

List any known foods you are allergic to or create discomfort after you consume:

Food	Known Reaction	Year Appeared
Example: Peanut, milk, eggs	Hives, eczema	2001 (After vaccination)
1.		
2.		

List any known foods you intentionally avoid or have an aversion to:

Food	Reason
Example: Greasy foods	Makes me get bloated, belch, sneeze, hives
1.	
2.	

List all the foods you consumed yesterday at each meal *(We understand that yesterday may not have been a typically day. However it is very important that you are as honest as possible. If you skipped a meal, please write down "SKIPPED MEAL")*.

Meal	All foods & beverages consumed
Example: Lunch	Burger with tomato, lettuce, bacon. fries, chocolate shake from In & Out
Breakfast	
Morning Snack	
Lunch	
Afternoon Snack	
Dinner	
Bedtime Snack	

8. Bowel Movement History

Frequency of bowel movements:

❑ More than 3 per day ❑ 2-3 per day ❑ 1 per day ❑ 4-6 per week ❑ 2-3 per week ❑ 1 or less per week

Color of fecal matter:

❑ Medium brown consistently ❑ Very dark or black ❑ Greenish ❑ Red or Blood is visible
❑ Dark brown consistently ❑ Yellow, light brown ❑ Greasy, shiny ❑ Pale, white or grey ❑ Varies a lot

Consistency of fecal matter:

❑ Soft and well formed ❑ Often floats ❑ Difficult to pass ❑ Diarrhea ❑ Thin, long and narrow
❑ Small and hard ❑ Loose but not watery ❑ Alternates between hard and loose

9. Female Health History *(to be completed by ALL women)*

Female Anatomy/Reproductive Health

Age of first period:

Birth Control and Contraceptives History:

Check off (√) all the contraceptive methods which you have used in the PAST and PRESENT:

- ❑ Male Condom
- ❑ Female Condom
- ❑ Diaphram
- ❑ Cervical Cap
- ❑ Contraceptive Sponge
- ❑ "Morning-after pill"
- ❑ The Pill (oral contraceptives)
- ❑ The Patch (Ortho evra)
- ❑ The Shot (Depo Provera)
- ❑ Nuva-Ring
- ❑ Subdermal Implants
- ❑ Tubal Ligation
- ❑ Mirena IUD
- ❑ Paraguard IUD
- ❑ Essure
- ❑ Implanon
- ❑ Hysterectomy
- ❑ Other

For each type of birth control you have used, please provide additional info below:

Name of Contraceptive	Reason for Taking	Year Started	Year Stopped	Any Side Effects?
Example: Ortho Tri-cyclen	Irregular Cycle	2013	Still taking	Facial Hair
1.				
2.				
3.				
4.				
5.				
6.				

While under the use of any and all of the birth control methods above, did you experience any of the following?:

- ❑ Thrush or Yeast overgrowth
- ❑ Mood instability
- ❑ Anger or neurotic
- ❑ Extreme weight gain
- ❑ Acne
- ❑ Sweet cravings
- ❑ Other _____
- ❑ Fatigue or depression
- ❑ Uncontrollable crying
- ❑ Heart palpitations
- ❑ Facial, or abdominal hair growth
- ❑ Blood clots or thrombosis
- ❑ Urinary tract infection
- ❑ Nausea, bloating or vomiting
- ❑ Headaches or migraines
- ❑ Red eyes during contact lens use
- ❑ Abnormal breast growth
- ❑ Worsening of menstrual cramps
- ❑ Heavier or less bleeding

Have you taken any "natural" bioidentical hormones? (such as DHEA, pregnenolone, testosterone, progesterone, estrogen)?

Bioidentical Hormone Name	Reason for Taking	Year Started	Year Stopped	Dose	Type (creams, gels, sublingual, drops, troche, oral)
Example: DHEA	Sweats	2013	Still taking	5	Drops
1.					
2.					
3.					
4.					

Infertility Treatment History

Check off (√) all infertility treatments which you have used in the PAST and PRESENT:

- ❑ In Vitro Fertilization (IVF) – Natural Cycle
- ❑ In Vitro Fertilization (IVF) – Mild Stimulation
- ❑ In Vitro Maturation (VM)
- ❑ Intrauterine Insemination (IUI)
- ❑ Gamete Inta-fallopian Transfer (GIFT)
- ❑ Acupuncture, Herbs, Detox, Chiropractic

For each type of Infertility Treatments you have used, provide additional info:

Type of Infertility Treatment	Reason for choosing	# of Rounds Undergone	Any Side Effects?
Example: IVF	Friend was successful	3	Skin is oily. Fatigue.
1.			
2.			
3.			

Pregnancy History

	Number
Number of Pregnancies:	
Number of Live births:	
Number of C-Section births:	
Number of Miscarriages:	
Number of Premature births:	
Number of Ectopic pregnancies:	
Number of Stillbirths:	

If you have been pregnant before, please fill out each of the below:

Year of Pregancy	Type (Vaginal delivery, C-Section, Miscarriage, Premature Birth, Ectopic Pregnancy, Stillbirth, Abortion)	Setting	Any Complications?
Example: 2011	Premature birth (31 weeks)	Hospital	Post-pardem depression
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

10-A. Menstrual Cycling History *(To be completed by all women who have NOT reached menopause)*

Date of your last menstrual period (LMP):	How many days is your current cycle?
Is your menstrual cycle always the same exact # of days? ❑ Yes ❑ No	
What is the average # of days (1st day of period to 1st day of next period:	
Is your menstrual cycle always the same exact # of days? ❑ Yes ❑ No	
Rate your usual menstrual blood flow: ❑ Heavy ❑ Moderate ❑ Light ❑ None	What is the number of Days of flow:
I use: ❑ Tampons ❑ Pads	Number used during each period:
Do you pass blood clots during your period? ❑ Yes. Every cycle ❑ Yes. Some cycles ❑ No	
Does blood color turn brown at the end of period: ❑ Yes ❑ No	
Do you experience any unusual or excessive vaginal discharge throughout the month? ❑ Yes ❑ No	
Describe the color, texture and smell of the discharge:	

Do you have any history of the following in the vaginal area?:

❑ Unusual or excessive discharge	❑ Swelling	❑ Itching	❑ Unpleasant Odor
❑ Painful periods	❑ Spotting	❑ Non-period bleeding	❑ Vaginal Dryness
❑ Lichens Sclerosis	❑ Vulvodynia	❑ Painful Intercourse	❑ Vaginal Skin thinning

Menstrual Cramps are: ❑ Mild ❑ Moderate ❑ Severe	Frequency: ❑ Monthly ❑ Other: _____
Medications I take for cramping:	

10-B. Menopausal Women Medical History *(to be completed by menopausal women)*

Are you in Menopause: ❑ Yes ❑ No	Menopause confirmed with ❑ Bloodwork ❑ Saliva Test ❑ No labwork confirmation
Date of last menstrual period:	How many months was your Perimenopause:
Do you currently, or have you, at any point since beginning menopause experienced spotting or bleeding? ❑ Yes ❑ No	
Please give an in depth explanation of how you perceive your experience transitioning into menopause (for example, please list symptoms, emotional changes, thoughts, stressors, etc.):	

11. Male Vitality Health Information *(to be completed by men only)*

Please check the boxes if you have a history of any of the following:

❑ Benign prostatic hypertrophy (BPH)
  ❑ Completed TURP; Date(s)_____
❑ Prostate or Testicular pain
❑ Erectile Dysfunction
  ❑ Premature Ejaculation ❑ Delayed Ejaculation
❑ Feeling of coldness or numbness in external genitalia
❑ Pain during urination
❑ Other_____

The average number of spontaneous morning erections per week: ❑ None ❑ 1 - 4 ❑ 5 - 7

If none, list the last year you recall having them: _____

12. Biological Decoding

List 3 of your most wonderful life experiences:

Wonderful Life Experience	Year(s) of Occurence
Example: Birth of son	2011
1.	
2.	
3.	

List 3 of your most painful or difficult life experiences:

Painful or Difficult Life Experience	Year(s) of Occurrence
Example: Divorce & loss of job	2013-2015
1.	
2.	
3.	

13. Readiness Assessment

Rate on a scale of: 5 (very willing) to 1 (not willing). In order to improve your health, how willing are you to:

Significantly modify your diet	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Take nutritional supplements each day	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Keep a record of everything you eat each day	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Modify your lifestyle (e.g. work demands, sleep habits)	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Practice relaxation techniques	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Engage in regular exercise	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Have periodic lab tests to assess progress	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1

Print name:

Signature: _____ **Date:** _____