White Pine Holistic Medicine
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Health History

Thank you for taking the time to fill out this form.

We look forward to reviewing it with you.

Personal Information

Date of first visit: _____

Name: _____

Date of birth: _____ Age: _____

What is your occupation? _____

Today's visit

Who referred you to White Pine Holistic Medicine? _____

What are your current health concerns?

Family History

Please list any family member who has ever had any of the following problems:

	Family member		Family member
High blood pressure:		Breast cancer (age):	
Heart Attack (age):		Colorectal cancer:	
Stroke (age):		Ovarian cancer:	
Blood problems:		Other cancer (type):	
Blood clots:		Depression:	
Bleeding tendency:		Other mental illness:	
Osteoporosis:		Alzheimer's disease:	
Hip fracture:		Alcohol abuse:	
Diabetes:		Drug abuse:	

List any other health problems in your family.

Major illness, surgery and injury history

List all operations, hospital stays, major injuries and illnesses.

Date	

Medical history

Please check all that apply. For past problems, list your age(s) at the time of the problem.

	Present	Past (age)		Present	Past (age)
Migraines	☐	☐	Diabetes	☐	☐
Blood pressure	☐	☐	Thyroid	☐	☐
Stroke	☐	☐	Asthma	☐	☐
High cholesterol	☐	☐	Arthritis	☐	☐
Heart attack or angina	☐	☐	Muscle or joint pain	☐	☐
Chest pain	☐	☐	Back pain	☐	☐
Blood clots	☐	☐	Seizures	☐	☐
Varicose veins	☐	☐	Eyesight	☐	☐
Easy bruising	☐	☐	Eating disorder	☐	☐
Anemia	☐	☐	Depression	☐	☐
Indigestion	☐	☐	Anxiety	☐	☐
Diarrhea	☐	☐	Mood swings	☐	☐
Constipation	☐	☐	Suicidal thoughts	☐	☐
Black or bloody stools	☐	☐	Stress	☐	☐
Hepatitis	☐	☐	Fatigue	☐	☐
Liver problems	☐	☐	Sleep problems	☐	☐
Gallbladder	☐	☐	Dizziness	☐	☐
Leaking urine or stool	☐	☐	Hair loss or growth	☐	☐
Breast problems	☐	☐	Skin	☐	☐
Endometriosis	☐	☐	Osteoporosis	☐	☐
Uterine fibroids	☐	☐	Broken bones	☐	☐
Infertility	☐	☐	Weight loss	☐	☐
Cancer	☐	☐	Physical abuse	☐	☐
Vaginal infections	☐	☐	Sexual abuse	☐	☐

List any other health problems here

Medication history

List everything you take regularly (medications and/or supplements, by prescription and/or over-the-counter)

Medications	Directions	Date started	Prescriber
Supplements			

Allergy history

Are you allergic to any medications (circle)? Yes No If yes, please list below.

Medication or other substance	Reaction

Health habits

Exercise
- o I do not exercise regularly.
- o I exercise _____ times per week for _____ minutes / hours at a time.
- o For exercise I like the following _____

Stress management
- o The major stressors in my life are: _____
- o To cope with stress, I do the following: _____
- o I do not have to deal with stress.

Smoking
- o I have never smoked.
- o I smoke _____ cigarettes daily. I have been smoking for _____ years.
- o I quit smoking _____ years ago. I smoked for _____ years.
- o I am ready to quit smoking.
- o I am not ready to quit smoking right now.

Alcohol
- o I do not drink alcohol.
- o I drink _____ servings of alcohol per week.
- o I am in recovery and have been sober since _____

Other drugs
- o I do not use recreational drugs.
- o I use the following recreational drugs: _____
- o I am in recovery and have been sober since: _____

Nutrition history

Describe any food allergies or intolerances.

Please list what you have eaten over the last 24 hours.