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Patient Health History

Patient Information:

Date:

Name: _____ DOB: _____
SS#: _____ DL# _____
Address: _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Home Phone: _____
Work Phone: _____ Email: _____
Place of Employment: _____
Occupation: _____ Referral: Y N Source: _____
Emergency Contact Name: _____ Phone Number: _____
Marital Status: Married Divorced Widowed Single
Age: _____ Height: _____ Weight: _____

If you are currently under the care of a physician or other health care professional, please provide name and primary condition treated: _____

Pharmacy Information:

Pharmacy: _____
Address: _____
City: _____ State: _____ Zip: _____
Pharmacy Phone Number: _____

Surgeries/Illness:

Surgeries/Illness & Dates: _____

Medical Devices (Pace Makers, Insulin Pump, etc.): _____

Allergies:

Drug, Food or Animal Allergies: _____

Sleep/Rest:

Restless Sleeping: Y N Insomnia: Y N Difficulty Falling Asleep: Y N
Daytime Drowsiness: Y N Early Morning Awakening: Y N
Do you use sleep aids: Y N Explain: _____
How Many Times Awake Per Night: _____ How many hours of sleep per night: _____

Dental History:

Have you had any dental work done in the last 12 months: Y N
Do you currently have any amalgam, silver, metal and/or gold fillings: Y N How many: _____
How long have you had these fillings: _____

Lifestyle Habits:

Tobacco History: Currently using tobacco: Y N Packs per day: _____ How many years: _____
If yes, what type: Cigarette Vape/Smokeless Cigar Pipe Patch/Gum
Desire to quit smoking: Y N Do you need assistance: Y N

Recreational Drugs: Y N What kind: _____ How Often: _____

Alcohol Intake: (1 drink= 5oz Wine, 12 oz Beer, or 1.5 oz Spirits)
How many drinks currently per week: None 1-3 4-6 7-10 10+

Caffeine Intake: How many cups per day: Coffee: None 1-3 4-6 7-10 10+
Soda: None 1-3 4-6 7-10 10+ Tea: None 1-3 4-6 7-10 10+

Do you use artificial sweetener: Y N What kind: _____

Water Intake: How many ounces of water do you drink per day: _____

Exercise: Y N How many days a week: _____ How long: _____
What kind: _____

Personal Health History: (Please circle what applies)

Headache, Shortness of Breath, Heart Palpitations, Heart Murmur, Chest Pain, Dizziness, Fainting, Circulation Problems, Asthma, Seasonal Allergies/Hay Fever, Hives, Rashes, Sinus Congestion, Bronchitis, Pneumonia, Ulcers, GI Disorder, Lactose Intolerance, Gallbladder Disease, Prostate Problems, Bowel Irregularity, Incontinence, Venereal Disease, Hepatitis, Gout, Frequent Infections, Anemia, Joint Pain, Rheumatoid Arthritis, Osteoarthritis, Osteoporosis/Osteopenia, Tetanus, Nervousness, Anxiety, Depression, Schizophrenia, Bipolar Disorder, Eating Disorder, Autism, ADD/ADHD, Colon Cancer, Breast Cancer, Ovarian Cancer, Scarlet Fever, Chronic Fever, Polio, Rheumatic Fever, Mumps, Rubella, Diphtheria, Muscle Aches, Fibromyalgia, Hypothyroid, Hyperthyroid, Hashimoto’s Thyroiditis, Sjogren’s Syndrome, Lupus, Clotting Disorder/Blood Clots, Obesity,
Other: _____

Have you had: Colonoscopy: Y N Date: _____ Bone Density: Y N Date: _____
Abdominal Aortic Aneurysm (AAA) Screen: Y N Date: _____
Hepatitis C Screen: Y N Date: _____

Have You Used a Weight Loss Program: Y N
If Yes, Please Describe: _____

Immunization History:

Have you had: Flu vaccine Y N Pneumovax Y N Varicella Zoster (shingles) vaccine: Y N
Others & Date: _____

Family History: (Please list what illness and what family member)

Kidney Disease Y N _____ Heart Disease Y N _____
Osteoporosis Y N _____ Stroke Y N _____
High Blood Pressure Y N _____ High Cholesterol Y N _____
Cancer Y N _____ Type _____
Epilepsy Y N _____ Glaucoma Y N _____
Macular Degeneration Y N _____ Obesity Y N _____
Diabetes Y N _____ Thyroid Disease Y N _____
Depression Y N _____ Anxiety Y N _____
Schizophrenia Y N _____ Bipolar Disorder Y N _____
Blood Clots Y N _____ Addiction Y N _____
Other _____

Medications/Supplements:

Dosage:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
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_____	_____

Complaints/Concerns:

Please list your primary symptoms in order of severity.

Problem	Onset	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Men Only:

Prostate Problems: Y N Describe: _____
Have you had a Prostate Assessment results (PSA): Y N Date: _____
Prostate Exam: Y N Date: _____ Vasectomy Y N Date: _____
Premature Ejaculation: Y N Erectile Dysfunction: Y N Decreased Libido: Y N
Difficulty Urinating: Y N Describe: _____
Have You Ever Taken Any Hormones (Natural/Synthetic): Y N
If Yes, Please Describe: _____

Women Only:

Menstrual Cycle: YNAge of Onset: _____ First day of Last Period: _____
Regular: YNDuration:_____ Heavy Bleeding: YNCramps: Y NMoodiness: YN
Depression: Y NDecreased Libido: Y NDecreased Arousal: YNVaginal Dryness: YN
Urinary Incontinence: YNFrequent Vaginal Infection: YNTubal Ligation: YN
Hysterectomy: YN Date: _____ Circle what applies: Uterus leaving cervix,
Uterus taking cervix, ovary-right, left. _____
Date of last Pap Smear: _____ Normal _____ Abnormal _____
Date of last Mammogram:_____ Normal _____ Abnormal _____
During your cycle, do you have symptoms of breast tenderness, water retention,irritability, moodiness (PMS):YN
Do you use birth control: Birth control pills Patch/Injection Nuva Ring Condom IUD
Diaphragm Other: _____

Have you skipped a period: Y NAre you in Menopause: Y N Age onset: _____
Date of last Bone Density: _____ Results: _____
Are you currently or have you taken: Estrogen Ogen Estrace Premarin Progesterone
Provera Other: _____

Have You Ever Taken Any Hormones (Natural/Synthetic): YN
If Yes, Please Describe: _____

Pregnancy History: Check box if yes and provide number

Pregnancies _____ Caesarean _____ Vaginal Deliveries _____
Miscarriage _____ Abortion _____ Living Children _____
Gestational DiabetesPost Partum Depression ToxemiaBaby over 8 pounds
Breast Feed, How Long: _____

Thank you for choosing Integrative Health Associates.

Print Patient Name:

Signature:

Date:

Parent or Guardian Signature:

Witness

Date: