Stangler Homeopathy

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HEALTH INVENTORY (This information is confidential and will not be released without your signed consent.)

Today's Date: _____ Birth date: _____

Name: _____

Address: _____

_____

Phone: (Work) _____ (Home) _____ (Cell) _____

Age _____ Sex _____ Height _____ Weight _____

Occupation: _____ Education: _____

Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact (Name): _____

Emergency Phone: _____

Relationship: _____

Referred by: _____

Family Physician: _____

Phone: _____

Current Health Problems: (example High Blood Pressure -10 years):

_____

_____

_____

FAMILY HISTORY

List the ages of your parents and if they are deceased, the cause of death:

_____

_____

List the ages of your siblings and if deceased, the cause of death:

_____

_____

_____

List the Names and ages of your children and if there is a current difficulty or problem:

_____

_____

_____

Check all items that apply to any blood relative (children, siblings, parents, grandparents, aunts or uncles):

Yes	Relationship	Yes	Relationship
☐ Alcohol/drug problem	_____	☐ High Blood Pressure	_____
☐ Allergy/asthma	_____	☐ High Cholesterol/fat	_____
☐ Anemia	_____	☐ Kidney Disease	_____
☐ Arteriosclerosis	_____	☐ Liver Disease	_____
☐ Binge Eating/Bulimia	_____	☐ Obesity	_____
☐ Bleeding Problem	_____	☐ Mental Illness	_____
☐ Cancer	_____	☐ Stroke	_____
☐ Diabetes	_____	☐ Suicide	_____
☐ Epilepsy/Seizure	_____	☐ Thyroid Disease	_____
☐ Heart Disease	_____	☐ Tuberculosis	_____
☐ Skin Disease	_____	☐ Gastro Intestinal Disease	_____
☐ Endocrine/Hormonal Imbalance	_____	☐ Syphilis	_____
		☐ Gonorrhea	_____

PAST HISTORY OF ILLNESS, INJURY AND MEDICAL PROBLEMS

List all surgeries and approximate dates:

_____

_____

_____

List all broken bones, or traumatic injuries including car accidents or concussions:

_____

_____

_____

List all other hospitalizations and dates:

_____

_____

_____

Check all that apply and when:

- ☐ Acne _____
- ☐ AIDS _____
- ☐ Alcohol/ Drug Problem _____
- ☐ Allergies _____
- ☐ Amalgams/ silver fillings _____
- ☐ Anemia _____
- ☐ Antibiotics more than once a year _____
- ☐ Anorexia _____
- ☐ Anxiety _____
- ☐ Arteriosclerosis _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Back Pain/Strain _____
- ☐ Binge Eating _____
- ☐ Bladder Infection _____
- ☐ Blood Clots _____
- ☐ Breast lumps _____
- ☐ Bronchitis _____
- ☐ Bulimia (self induced vomiting) _____
- ☐ Cancer _____
- ☐ Cataract _____
- ☐ Chemical Sensitivity _____
- ☐ Chicken Pox _____
- ☐ Chronic Fatigue _____
- ☐ Colds frequent _____
- ☐ Colitis _____
- ☐ Congenital Defect _____
- ☐ Counseling _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Ear Infection _____
- ☐ Eczema _____
- ☐ Endometriosis _____
- ☐ Epilepsy _____
- ☐ Epstein Barr/ infectious mono _____
- ☐ Fibrocystic Breasts _____
- ☐ Fibroids _____
- ☐ Gallbladder _____
- ☐ Problem _____
- ☐ Glaucoma _____
- ☐ Gout _____
- ☐ Hay Fever _____
- ☐ Hearing Problem _____
- ☐ Heart Attack _____
- ☐ Heart Failure _____
- ☐ Heart Problem _____
- ☐ Hemorrhoids _____
- ☐ Hepatitis _____
- ☐ Herpes _____
- ☐ Hiatal Hernia _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol/ triglycerides _____
- ☐ Hives _____
- ☐ Hypoglycemia _____
- ☐ Insomnia _____
- ☐ Kidney Infection _____
- ☐ Kidney Stones _____
- ☐ Kidney problem _____
- ☐ Liver Disease _____
- ☐ Menstrual Problem _____
- ☐ Mental Illness _____
- ☐ Migraine _____
- ☐ Nervous Condition _____
- ☐ Neurologic Problem _____
- ☐ Overweight (20lbs) _____
- ☐ Panic Attacks _____
- ☐ Pelvic Infection _____
- ☐ Peptic Ulcer _____
- ☐ Periodontal Disease _____
- ☐ Phlebitis _____
- ☐ Pneumonia _____
- ☐ Premenstrual Tension _____
- ☐ Prostate Problem _____
- ☐ Psychotherapy _____
- ☐ Reactions to Vaccinations _____
- ☐ Rheumatic Fever _____
- ☐ Root Canal _____
- ☐ Scarlet Fever _____
- ☐ Sexually Transmitted Disease _____
- ☐ Sinusitis _____
- ☐ Skin Problem _____
- ☐ Sleep Disorder _____
- ☐ Stroke _____
- ☐ Suicide Attempt _____
- ☐ Syphilis _____
- ☐ Steroids (cortisone/ prednisone) _____
- ☐ Thyroid Problem _____
- ☐ Tonsillitis _____
- ☐ Tooth Problems _____
- ☐ Tuberculosis _____
- ☐ Urine Problem _____
- ☐ Vaginitis _____
- ☐ Vision Problems _____
- ☐ Warts _____
- ☐ Other Problems _____

REVIEW OF SYSTEMS (check all that apply within the last 6 months)

- ☐ Chronic fatigue
- ☐ Mood Swings
- ☐ Chronic depression
- ☐ Trembling episodes
- ☐ Light- headed
- ☐ Food craving
- ☐ Frequent infection
- ☐ Night Sweats
- ☐ Swollen glands
- ☐ Skin rash
- ☐ Chills/Fever
- ☐ Change in wart or mole
- ☐ Change in skin/nails
- ☐ 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 of 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
- ☐ 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 or anxiety
- ☐ Irregular heartbeat
- ☐ Skips beats
- ☐ Palpitations
- ☐ Fast heart beat
- ☐ Heart murmur
- ☐ Swelling feet/legs
- ☐ Cold hands/feet
- ☐ Legs cramp at night
- ☐ Joint pain
- ☐ Pain or fatigue in legs when exercising
- ☐ 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 food
- ☐ Bloating of abdomen
- ☐ Bowel gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Clay colored stool
- ☐ Mucus in stool
- ☐ Hemorrhoids
- ☐ Rectal bleeding
- ☐ 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

WOMEN

Last menstruation _____

Age menstruation began _____

- ☐ Usual length of cycle
- ☐ Change in cycle
- ☐ Spotting between periods
- ☐ Discomfort with periods
- ☐ Premenstrual tension

Number of pregnancies _____

Number of live births _____

Number of abortions/ miscarriages _____

- ☐ Complications of pregnancy
- ☐ Infertility
- ☐ Used birth control pills
- ☐ Used IUD

Type of IUD _____

- ☐ Vaginal discharge
- ☐ Itching
- ☐ Painful intercourse
- ☐ Problem with sexual function
- ☐ Self-breast exam
- ☐ Lump in breast
- ☐ Abnormal pap smear

Date of last pap smear? _____

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

PERSONAL INFORMATION

List all prescription and non-prescriptions including dosage:

_____

_____

List all Vitamin and mineral supplements – type and dosage:

_____

_____

I am allergic to the following medications:

_____

_____

I am allergic to the following foods (include how food allergy was tested):

_____

_____

List favorite foods and cravings:

_____

_____

☐ Yes ☐ No I am now or have been a smoker?

For how many years? _____ How much?_____ When did you quit smoking? _____

How much coffee do you use per day?_____ How much Decaf per day? _____

I use (check all that apply): ☐ beer ☐ wine ☐ hard liquor

I consider myself a:

☐ non drinker ☐ social drinker ☐ heavy drinker ☐ alcoholic ☐ recovering alcoholic

☐ Yes ☐ No I use marijuana or other drugs.

☐ Yes ☐ No I participate in an exercise program.

☐ Yes ☐ No I exercise on a regular basis. Times per week/month: _____

☐ Yes ☐ No I think this is enough exercise.

☐ Yes ☐ No I would like to do more exercise.

I find my work: ☐ too demanding ☐ boring ☐ satisfactory ☐ very satisfying

☐ Yes ☐ No My sex life is satisfying?

☐ Yes ☐ No I sleep well?

I do the following for relaxation/recreation:

_____

_____

I worry about (circle): ☐ money ☐ job ☐ family life ☐ relationships ☐ other

☐ Yes ☐ No I currently see a psychotherapist or other mental health professional.

☐ Yes ☐ No I currently see a chiropractor, osteopath, or other physical therapy person.

☐ Yes ☐ No I have been arrested.

☐ Yes ☐ No My spiritual life is satisfactory.

☐ Yes ☐ No I am currently involved in a regular spiritual program.

Fears/phobias:

_____

_____

My last physical exam was: _____