Holistic Harmony MedSpa
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Medical History Form

Name: _____ Date of Birth: ___/___/_____ Date: ___/___/_____

Allergies: _____

Current Medications (Prescriptions and Non-Prescriptions):

Current Supplements:

Current Medical Problems:

Hospital Admissions/Surgeries:

Year	**Illness/Surgery**	**Year**	**Illness/Surgery**

Screening Tests:

Screen	**Date**	**Abnormal?**	**Screen**	**Date**	**Abnormal?**
Lipid Profile			Dental Exam		
Blood Sugar			Eye Exam		
Thyroid Panel			Skin Exam		
Mammogram			Rectal/Colonoscopy		
Bone Density			Vascular Ultrasound		
Pap Smear			Prostate Exam		

Immunizations:

Immunization	**Year of last**	**Immunization**	**Year of last**
Tetanus/Td		Pneumonia	
Influenza (FLU)		Hepatitis	

Family History (Write Family Member with Disease in Box):

Anemia	Alcoholism	Alzheimer's	Arthritis
Asthma	Bleeds easily	Cancer	Diabetes
Epilepsy	Glaucoma	Hay Fever	Heart Disease
Hepatitis	Hypertension	Lipid Disorder	Mental Illness
Osteoporosis	Stroke	Thyroid Disease	

Medical History: Mark "C" for Current, and "X" for Past.

	Ear Concerns		Hepatitis/Liver Problems
	Eye Concerns		Bloody/Tarry Stools
	Sinus Trouble		Hemorrhoids
	Sore Throats		Hernia
	Hoarseness		Overactive Bladder
	Hay Fevers/Allergies		Decrease in Urinary Force/Flow
	Pneumonia/Pleurisy		Painful Urination
	Bronchitis/Chronic Cough		Stress Incontinence
	Shortness of Breath		Hematuria
	Asthma/Wheezing		Kidney Stones
	Edema		Urinary Tract Infections
	Chest Pain		Blood in Urine
	High Blood Pressure		Anemia
	Heart Murmur		Bruise easily
	Palpitations/Arrhythmias		Cancer
	Dizziness/Syncope		Diabetes
	Loss of Coordination/Balance		Thyroid Disease
	Peripheral Artery Disease		Seizures
	Varicose Veins/Phlebitis		Strokes
	Cold/Numb Feet		Tremors
	Nausea/Vomiting		Numbness/Tingling
	Loss of Appetite		Headaches
	Difficulty Swallowing		Brittle Nails
	Heartburn		Hair Loss
	Peptic Ulcer		Caffeine Consumption
	Flatulence/Indigestion		Alcohol
	Joint Pain/Myalgia		Been Drunk in the past month? Yes No
	Osteoporosis/Osteopenia		Ever feel the need to stop drinking? Yes No
	Back Pain		Tobacco/Drug Use
	Arthritis		Sexually Transmitted Disease
	Fractures after Age 50		Mental Illness
	Gout		Suicidal Thoughts
	Chronic Abdominal Pain		Feelings of Worthlessness
	Crohn's/Colitis		Skin Disorders
	Irritable Bowel Syndrome		Aesthetic Concerns (Wrinkles)
	Frequent Constipation		Single/Married/Divorced (Circle One)
	Frequent Diarrhea		Number of Children
	Diverticulosis		

Rate the following categories on a scale from 0-10:

	Energy (10 is best)		General Well-Being (10 is best)
	Memory (10 is best)		Mood (10 is best)
	Concentration (10 is best)		Anxiety (10 is worst)
	Sleep (10 is best)		Mood Swings (10 is worst)
	Libido (10 is best)		Irritability (10 is worst)

Females

Age of Onset of Menstrual Periods: _____
Date of 1st Day of last Period: ___/___/___
Length of Cycle: _____days
Length of Flow: _____days
Are your Periods Regular or Irregular (Circle One)
Cramps: Mild Moderate Severe (Circle One)
Birth Control Method: _____
Night Sweats: Yes No (Circle One)
Hot Flashes: Yes No (Circle One)
Temperature Swings: Yes No (Circle One)
Number of Live Births: ____
Number of Miscarriages: ____
Did you ever breastfeed: Yes No (Circle One)
Vaginal Dryness: Yes No (Circle one)
Pain with Sexual Activity: Yes No (Circle One)

How do/did you feel during different days of the monthly fluctuations of your cycle? _____

_____

How do/did you feel a few days before and during your period? _____
How do/did you feel from the day of ovulation to the onset of heavy flow? _____
Did you gain weight or have an increase in breast size after starting birth control pills? _____
Did you feel better after starting birth control pills? _____

Males

Current Symptoms	**None**	**Mild**	**Moderate**	**Severe**	**Extreme**
Decrease in ability/frequency to perform sex					
Decrease in the number of morning erections					
Decrease in sexual desire					
Sensation of not emptying bladder					
Urinating again less than 2 hours after last urination					
Stop and start several times while urinating					
Finding it difficult to postpone urination					
Excessive sweating					

Describe your nutrition: _____

_____

How often do you exercise and what type of exercise do you do? _____

_____

What are you top 3 current sources of stress? 1._____
2. _____ 3. _____
What are your primary health concerns? 1. _____
2. _____ 3. _____