Helios Integrated Medicine

2525 4th Street
Boulder, CO 80304
T 303.499.9224
F 303.499.9593
heliosintegratedmedicine.com

Adult Health History Form
Date: _____/_____/_____

Name: _____Date of birth: ____/____/____

Allergies to medications _____

_____

Medications & Dosage:

_____
_____
_____
_____
_____
_____

Supplements:

_____
_____
_____
_____
_____
_____

Medical History:

	Good health	Poor health	Deceased	Cause of death	Stroke	Osteoporosis	Asthma/ allergies	Alcoholism	Depression	Diabetes	Kidney/ Bladder Trouble	Dementia	Cancer	Thyroid Disorder	Arthritis	Anxiety	Anemia	Heart Trouble	Hypertension	High Cholesterol	Stomach Trouble
Father																					
Mother																					
Siblings																					
Grandparents																					
Spouse																					
Children																					

Helios Integrated Medicine

2525 4th Street
Boulder, CO 80304
T 303.499.9224
F 303.499.9593
heliosintegratedmedicine.com

General:

Energy during the day: High ☐ Medium ☐ Low ☐
Exercise tolerance: Good ☐ Okay ☐ Poor ☐

What do you do for exercise, and how often? _____

_____

Any weight changes within the last year? _____ If so, how much? _____
Do you use a seat belt? _____
Do you use a cell phone while driving? _____

Nervous System:

__Depression __Startle easily __Flatness __ Migraines
__Anxiety __ Addictive behavior __ Seizures
__Irritability __Motivation __ Concussion If so, when? _____

Do you use tobacco? _____ If so, how much and for how long? _____

Recreational drug use? ____ If so, please list: _____

Men:

How often do you get up to urinate at night? _____
Erection problems___
Groin pain ___
Testicular pain ___
Do you perform self testicular exams? ___
Libido problems___
Sexually active: Yes ☐ No ☐
Prostatitis: Yes ☐ No ☐
Have you ever had an elevated PSA test: Yes ☐ No ☐ If so, what were the results? _____

Helios Integrated Medicine

2525 4th Street
Boulder, CO 80304
T 303.499.9224
F 303.499.9593
heliosintegratedmedicine.com

Women:
Do you have PMS symptoms? ____ Please describe if so: _____
Recurrent yeast infections: Yes ☐ No ☐
Birth control method _____ For how long? _____
Do you perform self breast exams regularly? ____
Have you ever been pregnant? ____ How many times? ____
Miscarriages ____
Abortions ____
Living children ____
Have you ever had an abnormal pap smear? ____ When? _____
Did you receive treatment for an abnormal pap smear? _____
Have you ever had a pelvic infection? ____ When? _____
Any problems or pain with intercourse? ___ If so, please describe _____
Do you use any vaginal hormones? _____

Cardiovascular:

__ Elevated blood pressure
__ Heart palpitations
__ Diabetes
__ Heart murmur
__ Elevated cholesterol
__ Chest pain

Helios Integrated Medicine

2525 4th Street
Boulder, CO 80304
T 303.499.9224
F 303.499.9593
heliosintegratedmedicine.com

Patient Name:_____

Genitourinary:

__ Urine leakage/incontinence
__ Kidney stones
__ Kidney infections
__ Urinary tract infections
__ Herpes Infections
__ History of STD's If so, please list: _____

Pulmonary:

__ Asthma
__ Shortness of breath
__ Cough
__ History of bronchitis/pneumonia

Muscles/Joints:

__ Arthritis
__ Gout
__ Headaches
__ Back Pain Where? _____
__ Broken Bones When? _____

Thyroid:

__ Temperature sensitive
__ Constipation
__ Fatigue
__ Dry skin
__ Weight gain
__ Hair loss

ENT:

__ Throat clearing
__ Glaucoma
__ Cataracts
__ Tonsillitis
__ Sinus infections
__ Airborne allergies
__ Hay Fever
__ Tonsillectomy

Skin:

__ Acne __ Eczema __ Skin cancer

Gut:

__ Gas
__ Heartburn
__ Constipation
__ Blood in stool
__ Crohn's Disease
__ Bloating
__ Belly pain
__ Diarrhea
__ Colitis
__ Belching
__ Anemia
__ Hemorrhoids
__ Ulcers
__ Parasitic infection
__ Diverticulitis

# of BM's per day ____

Helios Integrated Medicine

2525 4th Street
Boulder, CO 80304
T 303.499.9224
F 303.499.9593
heliosintegratedmedicine.com

Sleep:

Time to bed _____ Awaken at _____

How do you feel in the morning? _____

Do you use sleep aids? If so, please list._____

_____

__ Startle awake __ Gasping for air __ Shortness of breath
__ Trouble going to sleep __ Trouble waking up __ Observed apneas
__ Snoring

Trauma:

__ Motor vehicle accident(s)
__ Other_____

Hospitalizations Year Type Complications

_____

_____

_____

Diet:

Are you avoiding any foods? If so, please list._____

__ Food intolerance
__ Food allergies

Do you drink alcohol? ___ How many drinks per week? _____

Do you drink caffeine? ___ How often? _____

What do you do to relax? _____

Who is you biggest emotional support? _____

What is your biggest stressor? _____

What is your stress level from 1-10 (10 being the highest)? _____

Helios Integrated Medicine

2525 4th Street
Boulder, CO 80304
T 303.499.9224
F 303.499.9593
heliosintegratedmedicine.com

When was your most recent:

_____Bone density scan
_____ Fecal occult test
_____ Flu shot
_____ Pap smear
_____ Vision exam
_____ Vitamin D Test
_____ Cardiac stress test

_____Colonoscopy
_____ Tetanus shot
_____ Mammogram
_____ Pneumococcal shot
_____ Cholesterol check
_____ PSA

Foreign Travel:

Where	When	Illnesses	Vaccines