

Helios Integrated Medicine

350 Broadway, Suite 100
Boulder, CO 80305

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? _____

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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 murmur

___ Heart palpitations

___ Elevated cholesterol

___ Diabetes

___ Chest pain

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Patient Name: _____

Genitourinary:

- | | |
|---|---|
| <input type="checkbox"/> Urine leakage/incontinence | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Herpes Infections |
| <input type="checkbox"/> Kidney infections | <input type="checkbox"/> History of STD's If so, please list: _____ |

Pulmonary:

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

Muscles/Joints:

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Back Pain Where? _____ |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Broken Bones When? _____ |
| <input type="checkbox"/> Headaches | |

Thyroid:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Temperature sensitive | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hair loss |

ENT:

- | | |
|--|---|
| <input type="checkbox"/> Throat clearing | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Airborne allergies |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tonsillectomy |

Skin:

- Acne Eczema Skin cancer

Gut:

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Gas | <input type="checkbox"/> Bloating | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Belly pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Colitis | <input type="checkbox"/> Parasitic infection |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Belching | <input type="checkbox"/> Diverticulitis |

of BM's per day _____

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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 your biggest emotional support? _____

What is your biggest stressor? _____

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

