Helios Integrated Medicine

350 Broadway, Suite 100
Boulder, CO 80305
T 303.499.9224
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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																					

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

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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 ____

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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 you biggest emotional support? _____

What is your biggest stressor? _____

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

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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