Lifetime Health Personal Health History

Name____Date_________________
Address__________________________________ City: ________________________
State: ___________ Zip: ____________ Occupation: ___________________________

Phone (Home) ____________(Work) _______________(Cell) __________________

DOB: _____________ Age_____ Referral Source______________________________

Email: ____ # of Children: ____________

Drug Allergies: __________________________ Other Allergies: _________________

Birth Control (describe): ____

Current Meds and Vitamins: ____
____

Surgeries: (include dates): ____
____

Height: ____________ Weight: _________ Last Blood Pressure Reading ____________

Date of BP Reading _________ Current Treating Physician(s): _____________________
____

Family History:

Heart Disease High Blood Pressure Stroke Cancer Glaucoma Diabetes
Epilepsy Kidney Disease Thyroid Disease Mental Disorder Osteoporosis

Women Only

Menstrual Period Y___N___ Age of onset ________ Cramps Y ___ N ___
Regular Y ___ N ___ Irregular Y ___ N ____ Date of Last Period: ____________________
Duration (days) _________
Moodiness/Depression with Menses Y___N___ Last Pap Smear: ________________
Trouble with arousal or desire Y___N___
Vaginal Dryness Y__ N___ Last Mammogram: ______________
Frequent vaginal infections Y___N___
Losing urine w/ coughing or sneezing Y___N___ Last Chest X-Ray: ______________
Have you had a Hysterectomy? Y ___ N ___ Partial ___ Total ___ Date _______________ ________

Have you had an ablation? Y __ N __ Tubal Ligation? Y __ N __ Other? _____________

Men Only

Prostate problems Y___N___
Trouble Urinating Y___N___
Decrease in size of urinating stream Y___N___
Number of times urinating at night _________
Trouble with erectile dysfunction Y___N___
Trouble with premature ejaculation Y___N___
Decreased Sex Drive Y___ N___

Sleep: Difficulty falling asleep Y___ N___ Daytime drowsiness Y___ N___
Snoring Y___ N___ Early morning awakening Y___ N___
Wake Up Refreshed Y___ N___ Sleep Apnea Y___ N___

Habits

Smoke: Packs daily_____
How long? _____
Interested in stopping? ___

Coffee: Cups daily: _______
Other caffeine: ________ Diet Sodas ____

Alcohol: Type: _____________________
How many drinks _______daily _____ weekly

Personal Medical History

Headache Shortness of Breath Heart Palpitations Heart Murmur Chest Pain
Dizziness/Fainting Problems with Circulation Allergies/Hay Fever Asthma
Bronchitis Pneumonia Ulcer GI disorder Lactose intolerance
Gallbladder disease Prostate disease Bowel Irregularity Incontinence
Venereal disease Frequent infections Hepatitis Anemia Arthritis
Osteoporosis Nervousness Joint Pain Depression Gout Scarlet Fever
Chronic Fever Rheumatic Fever Mumps Measles Rubella
Polio Diphtheria Tetanus Muscle aches

Pace Makers or Any Other Medical Devices: ______________________________________
Do you have sugar cravings? Y ____ N ____. Carbohydrate Cravings? Y ____ No _____
If yes, please describe: ____
____

Have you ever been treated for a mental disorder? Y __ No ___
If yes, please describe: ____
Have you ever taken Natural Hormones or Synthetic Hormones? Y ___ No ____
If yes, name the hormones and describe your experience with the hormones:
____
____
____

Have you ever been involved in a Weight Loss Program(s)? Y__ No ___
Have you ever taken weight loss medications? Y __ No __
If yes, please describe program/medications: __________________________________
____
____

Primary Health Concern(s) /Objective(s):___________________________________
____
____
____
____
____

Signature: ____

Date: ___________________________________

NBH Lifetime Health

Males

Circle any symptoms you may have and mark the severity of any symptoms.

Severity:	*Mild*	*Moderate*	*Severe*
• **Fatigue**	_____	_________	_______
• **Poor resistance to stress**	_____	_________	_______
• **Depression**	_____	_________	_______
• **Anxiety**	_____	_________	_______
• **Complacency**	_____	_________	_______
• **Mood Swings**	_____	_________	_______
• **Loose or wrinkled skin**	_____	_________	_______
• **Pouches under the eyes**	_____	_________	_______
• **Loose skin folds under the chin**	_____	_________	_______
• **Drooping triceps**	_____	_________	_______
• **Increasing stomach size**	_____	_________	_______
• **Poor muscle tone**	_____	_________	_______
• **Wrinkled hands**	_____	_________	_______
• **Thinning skin / hair**	_____	_________	_______
• **Weight Gain / Trouble losing weight**	_____	_________	_______
• **Age over 40**	_____	_________	_______
• **Can't gain muscle with exercise**	_____	_________	_______
• **Feel like you are aging**	_____	_________	_______
• Overall decreased sexual desire	_____	_________	_______
• Diminished sense of well-being	_____	_________	_______
• Osteoporosis / Osteopenia	_____	_________	_______
• Decreased morning erections	_____	_________	_______
• Fatigue / loss of energy	_____	_________	_______
• Loss of ambition	_____	_________	_______
• Poor muscle tone/Loss of strength	_____	_________	_______
• Poor stamina	_____	_________	_______
• Increased breast tissue in males	_____	_________	_______
• Poor Memory	_____	_________	_______
• Decreased sexual thoughts	_____	_________	_______
• Difficulty getting up in the morning?	_____	_________	_______
• Need coffee, colas, salty or sweet snacks to keep going?	_____	_________	_______
• Allergies or asthma that started as an adult	_____	_________	_______
• Joint Pain	_____	_________	_______
• Frequent Infections	_____	_________	_______
• Chronic Fatigue	_____	_________	_______
• Hypoglycemia (low blood sugar)	_____	_________	_______
• Cravings for sweets	_____	_________	_______
• Shakiness relieved by eating	_____	_________	_______
• Lots of stress before symptoms began	_____	_________	_______
• Low blood pressure	_____	_________	_______
• Dizziness upon first standing	_____	_________	_______

- Food craving or sensitivities _____ ________ ______
- Constipation _____ ________ ______
- Decrease in memory _____ ________ ______
- Throat Clearing _____ ________ ______
- Headaches and migraines _____ ________ ______
- Dry Skin _____ ________ ______
- Slow Heartbeat _____ ________ ______
- High Blood Pressure _____ ________ ______
- Increased Cholesterol _____ ________ ______
- Cold Extremities (hands, feet) _____ ________ ______
- Depression _____ ________ ______
- Chronic Infections _____ ________ ______
- Increased LDL _____ ________ ______
- Low HDL _____ ________ ______
- Increased Tryglycerides _____ ________ ______
- Loss of outside 1/3 of eyebrow _____ ________ ______
- Muscle Cramps _____ ________ ______
- Swelling of hands and feet _____ ________ ______
- Cold Intolerance _____ ________ ______
- Reliance on coffee/stimulants _____ ________ ______
- Diabetes _____ ________ ______
- ADD / ADHD _____ ________ ______
- Hypothyroidism in family _____ ________ ______
- Oral Temp below 98.5 _____ ________ ______
- Puffy eyes and face _____ ________ ______
- Joint Aches and Pains _____ ________ ______
- Brittle Nails _____ ________ ______
- Tingling in fingers/feet _____ ________ ______
- Experiences Stiffness _____ ________ ______

Any history, complaints, history of complaints or other factors that you feel are relevant to any treatment plan that may be recommended for you.

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____
____
____

Health Objectives: ____
____
____
____

Printed Name: ____

Signature: _____________________________________ Date:______________________