# Braverman Wellness

at

## HEALTH HISTORY

**Name**________________________________________ **Today's Date** ____________________

**Age** ___________ **DOB**_________________ **Gender** M F T

**What would you like support with at this time?**

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

| **Please list your major health concerns/stressors.** | **How long occurring?** |
|---|---|
| 1. ______________________________________ | 1. ________________________ |
| 2. ______________________________________ | 2. ________________________ |
| 3. ______________________________________ | 3. ________________________ |
| 4. ______________________________________ | 4. ________________________ |
| 5. ______________________________________ | 5. ________________________ |

**Emergency Contact** ___________________________ **Relation** _______________________

**Emergency Contact Phone:** Home ____________________ Cell _______________________

**Name of Physician** ______________________________ Last Visit (M/Y) ____________

**Name of Gynecologist** ___________________________ Last Visit (M/Y) ___________

**Other types of practitioners seeing (type and name):**

## Lifestyle

Relationship Status ______________________________ # of times Married/Partnered ________

Divorced/Severed Partnership ______________ Widowed _______________

Currently sexually active? Yes No Number of current partners: __________________

Birth Control Method (if applicable)

____________________________________________________________________________________

History of sexually transmitted infections? If yes, please specify.

____________________________________________________________________________________

Current Occupation ___________________ How long? ________ Hours per week? ___________

Do you enjoy your work?

____________________________________________________________________________________

Passions/Interests

____________________________________________________________________________________

## Sleep/Energy Level

How many hours do you sleep? _________________ Do you sleep well? ____________________

Trouble falling asleep? __________________________ Wake during night? _________________

Do you wake rested? ________________________________ Use alarm to wake? ______________

How is your energy level during the day?

____________________________________________________________________________________

## Activity Level

___ Sedentary (little exercise)

___Very Active (6-7 days per week)

___ Light Activity (1-3 days per week)

___ Extra Active (hard daily exercise)

___ Moderate Activity (3-5 days per week)

## Food/Other

Meals per day _____ Snacks per day _____

Typical Breakfast ____________________________________________________________________

Typical Lunch _______________________________________________________________________

Typical Dinner_______________________________________________________________________

Snacks ______________________________________________________________________________

What kinds of foods do you crave? ____________________________________________________

Coffee (cups per day) ____________ Tea (cups per day) ______________ Type? _______________

Sodas per week? __________ Diet or Regular? ________________

Alcoholic (drinks per week) ______________Cigarettes (how many per day) _____________

Recreational Drugs ______________________________

**Medical History (Hospitalized, Surgery, Major Illness)**

***Year*** ***What?*** ***Treatment Received?***

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Medications/Herbs/Vitamins/Supplements (attach additional sheet if needed)**

***Type*** ***Dosage?*** ***For what condition?***

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Are you allergic to aspirin? Yes No**

**Mark conditions/illnesses in yourself or blood relatives with an "x." Add additional information about your condition or identify relative (i.e. for yourself, when diagnosed; for relative, please identify mother, father, grandmother, grandfather, brother, sister, aunt, uncle, daughter, son).**

| **Condition** | **Self** | **Blood Relative** | **Details about Self or Identify Relative** |
|---|---|---|---|
| Addiction | | | |
| Allergies/Asthma | | | |
| Arthritis | | | |
| Cancer | | | |
| Depression | | | |
| Diabetes | | | |
| Digestive Issues | | | |
| Gynecological Issues | | | |
| Headaches/Migraines | | | |
| Heart Disease | | | |
| High Blood Pressure | | | |
| Kidney Disease | | | |
| Lyme Disease | | | |
| Mononucleosis | | | |
| Obesity | | | |
| Osteoporosis | | | |
| Respiratory Disease | | | |
| Stroke | | | |
| Thyroid Disease | | | |

| GENERAL | | | |
|---|---|---|---|
| **Issue** | **Currently?** | **How long?** | **In past?** |
| Insomnia | | | |
| Dreams/Nightmares | | | |
| Fatigue | | | |
| Poor Memory | | | |
| Poor Concentration | | | |
| Recent Weight Loss | | | |
| Recent Weight gain | | | |
| Colds Hands/Feet | | | |
| Chills | | | |
| Bad Breath | | | |
| EYES | | | |
| Glasses/Contacts | | | |
| Blurred Vision | | | |
| Poor night vision | | | |
| Spots/Floaters | | | |
| Eye inflammation | | | |
| Double Vision | | | |
| Glaucoma | | | |
| Cataracts | | | |
| MUSCULOSKELETAL | | | |
| Joint pain/swelling | | | |
| Sore Muscles | | | |
| Weak Muscles | | | |
| Difficulty Walking | | | |
| Pain | | | |
| Limited Range of Motion | | | |

| HEAD AND NECK | | | |
|---|---|---|---|
| **Issue** | **Currently?** | **How long?** | **In past?** |
| Headaches | | | |
| Migraines | | | |
| Stiff Neck | | | |
| Dizziness | | | |
| Fainting | | | |
| Swollen Glands | | | |
| EARS | | | |
| Ringing | | | |
| Hearing Loss | | | |
| Hearing Aids | | | |
| Infections | | | |
| Earache | | | |
| Vertigo | | | |
| GASTROINTESTINAL | | | |
| Nausea | | | |
| Indigestion | | | |
| Abdominal Pain | | | |
| Diarrhea | | | |
| Constipation | | | |
| Lack of appetite | | | |
| Excessive Hunger | | | |
| Vomiting | | | |
| Gas/Bloating | | | |
| Heartburn | | | |
| Laxative Use | | | |
| Bloody Stool | | | |

| **NOSE, THROAT, MOUTH** | | | |
|---|---|---|---|
| **Issue** | **Currently?** | **How long?** | **In past?** |
| Sinus Infection | | | |
| Hay Fever/Allergies | | | |
| Sore Throat Often | | | |
| Trouble Swallowing | | | |
| Mouth/Tongue ulcers | | | |
| Frequent Colds | | | |
| Nosebleed | | | |
| Dry Nose | | | |
| Nasal Congestion | | | |
| Loss of Voice | | | |
| Thirst | | | |
| Excessive phlegm | | | |
| TMJ/Jaw Issues | | | |
| Facial pain | | | |
| Gum problems | | | |
| Dry Mouth | | | |
| Dental Problems? | | | |
| **SKIN** | | | |
| Hives/Rashes | | | |
| Itching | | | |
| Eczema/psoriasis | | | |
| Night Sweating | | | |
| Excess Sweating | | | |
| Dry Skin | | | |
| Easily Bruised | | | |
| Changes in moles/lumps | | | |

| **RESPIRATORY** | | | |
|---|---|---|---|
| **Issue** | **Currently?** | **How long?** | **In past?** |
| Difficulty breathing | | | |
| Wheezing | | | |
| Asthma | | | |
| Chronic Cough | | | |
| Wet Cough | | | |
| Dry Cough | | | |
| Cough up phlegm | | | |
| Cough up blood | | | |
| Shortness of breath | | | |
| Tight chest | | | |
| Pneumonia | | | |
| **CARDIOVASCULAR** | | | |
| High Blood Pressure | | | |
| Low Blood Pressure | | | |
| Chest Pain | | | |
| Chest Tightness | | | |
| Palpitations | | | |
| Irregular Heart Beat | | | |
| Poor Circulation | | | |
| Swollen Ankles | | | |
| Phlebitis | | | |
| Anemia | | | |
| Heart Disease | | | |
| Heart Murmur | | | |
| Run Cold | | | |
| Run Hot | | | |

| NEUROLOGICAL | | | |
|---|---|---|---|
| **Issue** | **Currently?** | **How long?** | **In past?** |
| Seizures | | | |
| Tremors | | | |
| Numbness/Tingling | | | |
| Pain | | | |
| Paralysis | | | |
| Poor coordination | | | |
| **MENTAL/EMOTIONAL** | | | |
| Depression | | | |
| Mood Swings | | | |
| Irritability/Frustration | | | |
| Trouble Relaxing | | | |
| Loneliness | | | |
| Sensitive | | | |
| Cry Frequently | | | |
| Worry Frequently | | | |
| Compulsive Behaviors | | | |
| Difficulty Focusing | | | |
| Hopeless Outlook | | | |
| Suicidal Thoughts | | | |
| Lose Temper | | | |
| **MEN ONLY** | | | |
| Impotence | | | |
| Premature Ejaculation | | | |
| Nocturnal Emission | | | |
| Pain/Itching Genitals | | | |
| Testicular Lumps | | | |
| Increased/Decreased Libido | | | |

| URINARY | | | |
|---|---|---|---|
| **Issue** | **Currently?** | **How long?** | **In past?** |
| Pain on Urination | | | |
| Frequent Urination | | | |
| Urgent Urination | | | |
| Blood in Urine | | | |
| Incontinence | | | |
| Incomplete Urination | | | |
| Bedwetting | | | |
| Wake to Urinate | | | |
| History of UTI | | | |
| Kidney Issues | | | |
| **WOMEN ONLY** | | | |
| Pregnant Now? | ____Yes ____No | | |
| # of Pregnancies | | | |
| # of Live Births | | | |
| # of Miscarriages | | | |
| # of Abortions | | | |
| Menopause | ____Yes ____No | | |
| Irregular Periods | | | |
| Excessive Bleeding | | | |
| Blood Clots | | | |
| Breast Tenderness | | | |
| Abnormal Pap | | | |
| Vaginal Infections | | | |
| Vaginal Pain/Itching | | | |
| Uterine Fibroids | | | |
| Endometriosis | | | |
| Increased/Decreased Libido | | | |
| Breast Lumps/Cysts | | | |