Corina B. Going, ND
3402 6th Avenue, Tacoma, Washington 98406
Phone: (253) 341-9410 Fax: (253) 442-6144

HEALTH HISTORY

Name_____ Date _____DOB _____

MEDICATIONS
List all current medications (prescription and nonprescription drugs), herbs and supplements with dosages.

_____
_____
_____
_____

ALLERGIES
List any allergies you have to drugs, food or environmental agents. Please indicate what type of reaction you have.

_____
_____

CHILDHOOD HEALTH
Generally described as: ☐ Good ☐ Fair ☐ Poor

Please indicate which, if any, of the following illnesses you have had.

☐ Asthma	☐ German measles	☐ Mumps	☐ Whooping cough
☐ Scarlet fever	☐ Hepatitis	☐ Chicken pox	☐ Rheumatic fever
☐ Diphtheria	☐ Measles		

Vaccinations: (year, type, adverse reactions?)_____
_____

HABITS/LIFESTYLE
Please circle and/or give a brief description where indicated
Alcohol: How much? _____ How often? _____
Tobacco: Type: ☐smoke ☐chew How long used? _____
Caffeine: How much? _____
Recreational drugs: How much? _____ How long used? _____
Diet restrictions _____

Food cravings _____

Exercise program _____

Average hours of sleep _____ Do you wake rested? Choose

Do you sleep well? _____

Occupation _____ Do you like your job? Choose

Stress level (home/job/other) _____

Living situation (house/apt, number in household, etc.) _____

_____

Single/Committed relationship/Married/Divorced (please circle the situation that applies to you)

Social life/activities _____

Spiritual practice _____

FAMILY HISTORY

Fill in all that apply

	Father	Mother	Brother(s)	Sister(s)	Spouse	Other
Age (if living)						
Age at death						
General health						
Alcoholism	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Other (describe)						
Other (describe)						

PERSONAL HISTORY

Circle any of the following illness that you have had.

☐ Mononucleosis
☐ Rheumatic fever
☐ Angina pectoris
☐ Heart attack
☐ Other heart disease
☐ High blood pressure
☐ Kidney disease
☐ Gout
☐ Anemia
☐ Hay fever
☐ Other _____

☐ Asthma
☐ Frequent lung infections
☐ Emphysema
☐ Diabetes
☐ Tuberculosis
☐ Cancer
☐ Freq kidney/bladder infections
☐ Nervous breakdown
☐ Depression
☐ Alcoholism

☐ Stomach ulcer
☐ Colitis
☐ Gallbladder disease
☐ Jaundice
☐ Hepatitis
☐ Arthritis
☐ Migraine headache
☐ Thyroid disease
☐ Sexually transmitted disease
☐ HIV or AIDS

List all operations and approximate date _____

_____

_____

List all hospitalizations (other than operations) with reason admitted and approximate date

_____

_____

List all serious injuries (other than above) with approximate date _____

_____

_____

GENERAL HEALTH

Date of last physical exam _____ dental exam _____ eye exam _____
Weight _____ Weight 1 year ago _____
Height _____

REVIEW OF SYSTEMS

Circle which, if any, of the following symptoms you currently have.

Dizziness	Persistent hoarseness	Black or tarry stool
Fatigue	Lump in the throat	Nausea
Fever	Sore tongue or mouth	Bloating/gas
Weight loss or gain (unexplained)	Bleeding gums	Rectal pain
Swollen glands	Dental problems	Frequent urination
Insomnia	Frequent chest colds	Large amount of urine
Anxiety/depression	Persistent cough	Pain with urination
Appetite or thirst changes	Coughing up blood	Urinate at night
Night sweats	Short of breath	Trouble urinating
Cold hands/feet	Short of breath at night	Dribbling urine
Itching	Irregular heart beat	Lose urine when coughing
Rashes	Chest pain/tightness	Genital sores
Skin growths	Swelling feet/ankles	Genital discharge
Slow wound healing	Easy bruising	Pain during intercourse
Headache	Blood clots/phlebitis	Memory changes
Hair loss/weak nails	Abdominal discomfort	Seizures
Eye pain	Burping	Fainting
Vision changes	Difficulty swallowing	Coordination changes
Hearing changes	Indigestion/heartburn	Changes in strength
Ringing/buzzing in ear	Vomiting blood	Numbness/tingling
Earaches/discharge	Constipation	Neck/back pain
Nasal discharge	Diarrhea/loose stools	Muscle pain
Nosebleeds	Change in bowel habit	Joint pain
Sinus problems	Hemorrhoids	
Frequent sore throats	Bleeding from rectum	

For women only

Age menses began _____ Last menstrual period _____
Length of menses _____ Number of pregnancies _____
Type of birth control used _____ Number of abortions _____
Type of STD protection used _____ Number of miscarriages _____
Last breast exam/pap _____ Normal? If not, describe _____

Circle which, if any, of the following symptoms you currently have

Vaginal discharge	Heavy menses	Breast lumps
Pain with intercourse	Missed menses	Breast tenderness
Painful menses	Bleed btwn menses	Nipple discharge

For men only

Date of last prostate exam _____ Normal? If not, describe _____
Type of birth control used _____
Type of STD protection used _____