Julie OBrien - Homeopathic Practitioner
Health Inventory
(This information is confidential and will only be released with your signed consent)

Name: ____ Birth date: ______________________
Last First Initial

Address: ____ Age_____Sex____Height______Weight_____

City: ______________________ State/ZIP______________ Legal Status: S M D Sep W

Phone: W__________________ H__________________ C__________________ Email: ______________________

Okay to leave a message by phone? Home________ Cell_______ Work________ Occupation: ______________________

If under 18, parent's name/address ____

Emergency Contact: Name ______________________ Phone __________________ Relationship ________________

Main Concern(s): ____

____

____

FAMILY HISTORY

☐ *Check if family history is unknown*

Relative	Age	If deceased, cause of death
Father		
Mother		
Siblings		

Children	Age	Problems

Check items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles).

YES	RELATIONSHIP
☐ Alcohol/Drug problem	______________
☐ Allergy/Asthma	______________
☐ Anemia	______________
☐ Arthritis	______________
☐ Binge eating/Bulimia	______________
☐ Cancer	______________
☐ Diabetes	______________
☐ Epilepsy/Seizure	______________
☐ Gastro Intestinal	______________
☐ Gonorrhea	______________
☐ Heart Disease	______________
☐ High Blood Pressure	______________

YES	RELATIONSHIP
☐ High Cholesterol	______________
☐ Hormonal Imbalance	______________
☐ Kidney/Liver Disease	______________
☐ Mental Illness	______________
☐ Obesity	______________
☐ Skin Disease	______________
☐ Stroke	______________
☐ Suicide	______________
☐ Syphilis	______________
☐ Thyroid Disease	______________
☐ Tuberculosis	______________

Please turn page.

Past History of Illness and Medical Problems

Surgery: List all surgery and approximate dates		Other hospitalizations and dates	

Broken bones and/or traumatic injuries (*include all car accidents or concussions/head injuries)*		Current health problems *(example: high blood pressure—10yrs)*	

Past History

YES		WHEN	YES		WHEN	YES		WHEN
☐	Alcohol/Drug problems		☐	Gonorrhea		☐	Respiratory problems	
☐	Allergies/Hay fever		☐	Gout		☐	Rheumatic fever	
☐	Amalgams/silver fillings		☐	Headaches/Migraine		☐	Root canal	
☐	Anemia		☐	Hearing problems		☐	Scarlet fever	
☐	Antibiotics (frequent use)		☐	Heart problems		☐	Seizure/Convulsions	
☐	Anxiety		☐	Hemorrhoids		☐	Sexual dysfunction	
☐	Arthritis		☐	Hepatitis		☐	STDs	
☐	Asthma		☐	Herpes		☐	Sinusitis	
☐	Back pain/strain		☐	Hives		☐	Skin problems	
☐	Bladder infections		☐	High/low blood pressure		☐	Sleep disorder	
☐	Blood clots		☐	High cholesterol		☐	Steroid use	
☐	Bowel problems		☐	HIV/AIDS		☐	Stroke	
☐	Breast lump		☐	Hypoglycemia		☐	Suicide attempt	
☐	Cancer		☐	Insomnia		☐	Syphilis	
☐	Chemical sensitivity		☐	Kidney problems		☐	Thyroid problems	
☐	Chicken pox		☐	Liver disease		☐	Tooth problems	
☐	Chronic fatigue		☐	Measles		☐	Tuberculosis	
☐	Congenital defect		☐	Menstrual problems		☐	Urinary problems	
☐	Dental problems		☐	Mental Illness		☐	Vaginitis	
☐	Depression		☐	Mumps		☐	Vascular problems	
☐	Diabetes		☐	Nervous condition		☐	Vision problems	
☐	Digestive problems		☐	Neurologic problems		☐	Warts	
☐	Eating disorders		☐	Over/under weight		☐	Other problems	
☐	Ear infection		☐	Panic attacks				
☐	Eczema		☐	Peptic ulcer				
☐	Endometriosis		☐	Phlebitis				
☐	Epilepsy		☐	Pneumonia/Bronchitis				
☐	Eye/vision problems		☐	Premenstrual tension				
☐	Fibroids		☐	Prostate problems				
☐	Gallbladder problems		☐	Reaction to vaccinations				

Review of Systems

Check if you have had these symptoms ***in the last 6 months***

- ☐ Mood swings
- ☐ Trembling episodes
- ☐ Light-headedness
- ☐ Frequent infection
- ☐ Night sweats
- ☐ Swollen glands
- ☐ Skin rash
- ☐ Chills/fever
- ☐ Change in skin/nails
- ☐ Change in wart/mole
- ☐ Abnormal bleeding/bruising
- ☐ Change in hair loss/growth
- ☐ Irritability
- ☐ Restlessness
- ☐ Dizziness
- ☐ Balance problems
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Fainting
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Excessive tearing/itching
- ☐ Dry mouth
- ☐ Excessive salivation
- ☐ Bleeding gums
- ☐ Bloody/yellow sputum
- ☐ Shortness of breath
- ☐ Pain/discomfort while eating
- ☐ Nausea/vomiting
- ☐ Change in diet

Women

Last menstrual period: ____________________

Usual length of cycle ____________________

Usual length of period ____________________

Age menstruation began ____________________

Age at menopause ____________________

Number of pregnancies ____________________

Number of live births ____________________

Number of abortions/miscarriages____________________

- ☐ Complication of pregnancy
- ☐ Used birth control pills
- ☐ Used IUD; Type: ____________________
- ☐ Change in cycle
- ☐ Spotting between periods
- ☐ Discomfort with periods
- ☐ Premenstrual tension
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Itching
- ☐ Self breast examination
- ☐ Problem with sexual function
- ☐ Lump in breast
- ☐ Abnormal pap smear
- ☐ Infertility

Date of last pap smear ____________________

Men

- ☐ Enlarged prostate
- ☐ Decreased urine stream
- ☐ Unable to interrupt stream
- ☐ Dribbling after urination
- ☐ Pus or drainage from penis
- ☐ Genital swelling/rash
- ☐ Problem with sexual function

Do you believe you have had an adverse reaction to a vaccination? If so, please list which vaccination(s) and approximate dates:

____

____

____

Current Medications

List all prescription and non-prescription medications including dosage

____

____

____

____

____

____

Vitamin and Mineral Supplements

Type and dosage

____

____

____

____

____

____

Allergies

I am allergic to the following medications:

____

____

____

____

____

____

Food allergies and method of testing

____

____

____

____

____

____

Please turn page.

Personal History

Lifestyle

List your favorite foods or cravings:

____
____
____
____
____
____

I am now or have been a smoker. ☐Yes ☐No
If yes:
How many years have you smoked? ____________
How much? ____________
When did you quit? ____________

I estimate my use of:
coffee:__________ cups/day decaf:__________ cups/day

I consider myself a ☐non-drinker ☐social drinker ☐heavy drinker ☐alcoholic ☐recovering alcoholic

I use: ☐marijuana ☐other drugs:______________

I have participated in an exercise program. ☐Yes ☐No

I exercise on a regular basis. ☐Yes ☐No
__________times __________week/month

I currently see a chiropractor, osteopath, or other physical therapy practitioner: ☐Yes ☐No

My last physical exam was______________________

I find my work ☐too demanding ☐boring ☐satisfactory ☐very satisfactory

Interests/Hobbies

____
____
____
____
____
____

My sex life is satisfactory ☐Yes ☐No

I do the following for relaxation/recreation: ____________
____
____

My spiritual life is satisfactory. ☐Yes ☐No

I am currently involved in a regular spiritual program: ☐Yes ☐No

I sleep well. ☐Yes ☐No

I worry about: ☐money ☐job ☐family life ☐relationships ☐other______________________

I have been a victim of abuse. ☐physical ☐sexual ☐emotional

Are you fearful of: ☐animals ☐people
☐being alone ☐darkness ☐death ☐diseases
☐robbers ☐sudden noises ☐thunder ☐the future
☐high places ☐the unknown ☐other ____________
____
____

Any additional information about yourself that you feel we have missed:

____
____
____
____
____
____
____
____
____
____
____