EURO-MED, LLC

34975 N North Valley Pkwy
Bldg 6, Ste. 138
Phoenix, AZ. 85086
602-404-0400(phone); 602-404-0403(fax)

INITIAL HISTORY FORM

Patient Name: _____

Today's Date: _____ Date of Birth: _____

Primary Concern: _____

List in Order of Importance, your Goals for working with your Physician:

1. _____
2. _____
3. _____
4. _____

Primary Care Physician: _____ Phone #: _____

Primary diagnosis: _____

Family History

	Father	Mother	Siblings	Grandparents
Age if Living:	_____	_____	____	_____
Age when died:	_____	_____	____	_____
Reason for death:	_____	_____	____	_____

CANCER Type (if had): _____

High Blood Pressure	Y	N	Y	N	Y	N	Y	N
Heart Attack/Stroke	Y	N	Y	N	Y	N	Y	N
Heart Disease	Y	N	Y	N	Y	N	Y	N
Asthma/Allergies	Y	N	Y	N	Y	N	Y	N
Mental Illness	Y	N	Y	N	Y	N	Y	N
TB	Y	N	Y	N	Y	N	Y	N
Auto-Immune Disease	Y	N	Y	N	Y	N	Y	N
Diabetes Mellitus	Y	N	Y	N	Y	N	Y	N
Osteoporosis	Y	N	Y	N	Y	N	Y	N

List All Surgeries and Hospitalizations/Accidents/Injuries/Stitches including date occurred:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

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Please note When and Why you have had each of the following:

X-rays	_____	MRI/Cat Scans	_____
Ultrasounds	_____	Last Dental Visit	_____
TB Test	_____	Blood Transfusion	_____
HIV test		Last Eye Exam	
	_____		_____

Did you have the following Diseases (D), Get Immunized (I) or Neither (N)?

Measles	D I N	Chicken pox	D I N	Hemophilus	D I N
Tetanus	D I N	Whooping Cough	D I N	Rubella	D I N
German Measles	D I N	Mumps	D I N	Hepatitis B	D I N

List Yes (Y), No (N), or Past (P) regarding the use of the following:

Alcohol	Y N P	How often and how much if yes/past _____
Any Alcohol Addiction	Y N P	
Any Alcohol Treatment	Y N P	
Recreational Drugs	Y N P	
Any Drug Treatment	Y N P	
Any Drug Addiction	Y N P	
Antacids	Y N P	
Analgesics	Y N P	
Soda Pop	Y N P	Ounces per day if yes/past _____
Smoking	Y N P	Packs/Day & Number of Days _____
Steroids	Y N P	
Laxatives	Y N P	
Coffee	Y N P	Cups /Day if yes/past _____

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Patient Name: _____

List Allergies, Sensitivities and Intolerances:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Review of Systems:

Present Weight: _____ Weight one month ago: _____Weight one year ago: _____
Height: _____
Maximum weight and when: _____ Minimum weight as adult and when: _____
Ideal Weight: _____

Regarding the next long section: Please indicate on a scale of 0-10 (0 being none and 10 being the best) the following:

Rate your energy: _____
Are you fatigued now? _____
If you have fatigue, when in morning, afternoon, evening is it the worst? _____
If you have fatigue, can you do what you need to do during the day? _____
Rate of Pain ____ Is it relieved by anything? _____ If so what? _____

	SKIN		
Rash	Y N P	Color Change	Y N P
Hives	Y N P	Lump	Y N P
Psoriasis/eczema	Y N P	Itchy	Y N P
Dry	Y N P	Warts/Moles	Y N P
Cancer of the skin	Y N P	Excessive Perspiration	Y N P
Suspicious Lesions	Y N P	Absent Perspiration	Y N P
	HEAD		
Headache	Y N P	Migraine	Y N P
Dandruff	Y N P	Head Injury	Y N P
Oil/dry hair	Y N P	Hair loss	Y N P
	NOSE		
Frequent Colds	Y N P	Nosebleeds	Y N P
Congestion	Y N P	Post Nasal Drip	Y N P
Polyps	Y N P	Seasonal Allergies	Y N P

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IMMUNITY

Frequent Infections	Y N P	
Allergies	Y N P	
Auto-Immune	Y N P	
Cancer	Y N P	Type _____
HIV/Aids	Y N P	

EYES

Dry/Watery	Y N P	Blurry Vision	Y N P
Double Vision	Y N P	Cataracts	Y N P
Glaucoma	Y N P	Styes	Y N P
Strain	Y N P	Discharge	Y N P
Itchy	Y N P	Dark Under Eyelid	Y N P
Light Sensitivity	Y N P		

MOUTH/THROAT

Canker sores	Y N P	Cold Sores	Y N P
Sore Throat	Y N P	Gum Disease	Y N P
Dentures	Y N P	Cavities	Y N P
Loss of Taste	Y N P	Hoarseness	Y N P
Root Canals	Y N P (#)	Difficulty Swallowing	Y N P
Amalgam Fillings	Y N P		

NECK

Stiffness	Y N P	Swollen Glands	Y N P
Full Movement	Y N P	Tension	Y N P

RESPIRATORY

Cough	Y N P	TB	Y N P
Shortness of Breath with exertion	Y N P	Bronchitis	Y N P
Shortness of Breath sitting	Y N P	Pneumonia	Y N P
Shortness of Breath lying down	Y N P	Asthma	Y N P
Wheezing	Y N P	Painful Breathing	Y N P

CARDIOVASCULAR

High blood pressure	Y N P	Rheumatic Fever	Y N P
Low blood pressure	Y N P	Murmurs	Y N P
Arrhythmias	Y N P	Palpitations	Y N P
Edema	Y N P	Chest Pain	Y N P
Heart Attack	Y N P	Faint Spells	Y N P
Stroke	Y N P	Ankle Swelling	Y N P
HTN	Y N P	Shortness of Breath	Y N P

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URINARY TRACT

Incontinence/lack of control	Y N P	Pain with Urination	Y N P
Frequent Infections	Y N P	Kidney Stones	Y N P
Urgency	Y N P	Discharge/Blood	Y N P
Difficult Start Urination	Y N P	Urinate at night	Y N P

GASTROINTESTINAL

Heartburn	Y N P	Bowel Movement Frequency	____/day
Indigestion	Y N P	Recent BM Changes	Y N P
Bloating	Y N P	Diarrhea	Y N P
Nausea	Y N P	Constipation	Y N P
Vomiting	Y N P	Hemorrhoids	Y N P
Change in Appetite	Y N P	Gall Bladder Disease	Y N P
Pancreatitis	Y N P	Liver Disease	Y N P
Ulcer	Y N P	Hepatitis	Y N P
Abdominal Pain	Y N P	Blood/Black Stools	Y N P

MALE GENITALIA

Testicular pain/swelling	Y N P	Sexually Active	Y N P
Hernia	Y N P	S.T.D.	Y N P
Discharge	Y N P	Prostate Disease/Symptoms	Y N P
Impotency	Y N P		Hetero
		Sexual Orientation	Homo
			Bi

FEMALE GENITALIA

Age Period Began	_____	How often period occurs	_____
How long period lasts	_____	Heavy menstrual bleeding	Y N P
Menstrual cramping	Y N P	Menstrual Pain	Y N P
PMS	Y N P	Food Cravings	Y N P
Times Pregnant	_____	How many births	_____
Miscarriages	Y N P	Abortions	Y N P
Last PAP smear	_____	Diagnosis	_____
Any abnormal PAPS	Y N P	When was Abnormal	_____
Menopausal since what age	_____	Use of Hormones	Y N P
Type of Hormones used	_____	Healthy Libido	Y N P
Dry Vagina	Y N P	Sexually Active	Y N P
Pain with intercourse	Y N P	Vaginitis	Y N P
S.T.D.	Y N P	Mammography	Y N P
	Hetero	If yes, what were results	_____
Sexual Orientation	Homo	Thermography	Y N P
	Bi	If yes, what were results	_____

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			MUSCULOSKELETAL		
Weakness	Y N P		Arthritis	Y N P	
Stiffness	Y N P		Leg Cramps	Y N P	
Osteoporosis	Y N P		Pain	Y N P	
Back Pain	Y N P		Muscle Cramps	Y N P	
Joint Pain	Y N P		Muscle Weakness	Y N P	
Joint Swellings	Y N P				
			NERVOUS		
Tremors	Y N P		Sciatica	Y N P	
Paralysis	Y N P		Carpal Tunnel Syndrome	Y N P	
Tingling/Numbness	Y N P		Fainting	Y N P	
Seizures	Y N P		Language Problems	Y N P	
Transient paralysis	Y N P		Unsteadiness	Y N P	
			MENTAL/EMOTIONAL		
Depression	Y N P		Anger/Irritability	Y N P	
			Trauma	Y N P	
Suicidal	Y N P		High strung or tense	Y N P	
Anxiety	Y N P		Fear/Panic	Y N P	
Eating Disorder	Y N P		Psych Hospitalization	Y N P	
Bipolar	Y N P		Obsessive Compulsive Disorder	Y N P	
Memory Loss	Y N P		Hallucinations	Y N P	
Paranoia	Y N P		Panic Attacks	Y N P	
			ENDOCRINE		
Thyroid	Y N P		Diabetes	Y N P	
			Abnormal bruising	Y N P	
Cold Intolerance	Y N P		Bleeding	Y N P	
Heat Intolerance	Y N P		Enlarged Lymph nodes	Y N P	
Increased thirst	Y N P		Increased appetite	Y N P	
Large quantities of urine	Y N P				
			CONSTITUTIONAL		
Fever	Y N P		Malaise	Y N P	
Chills	Y N P		Sedation	Y N P	
Sweats	Y N P		Weight gain/loss	Y N P	
Loss of Appetite	Y N P			Y N P	

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EXERCISE

How often do you exercise? _____ What type of exercise? _____
For how long? _____

SLEEP

How long per night? _____ If you wake up frequently, what is the reason? _____

Nightmares Y N P Wake refreshed Y N P Must nap during day Y N P
Sleep Walk Y N P Grind teeth Y N P Snore Y N P
Insomnia Y N P

TOXIN EXPOSURE

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollutant were you exposed to? _____
Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____
Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____
Are you particularly sensitive to perfumes, gasoline or other vapors? _____
Do you use pesticide, herbicides or other chemicals around your home? _____

SOCIAL LIFE

Enjoy your job: Y N P Hours worked per week: _____ Highest Level of Education: _____
Active Spiritual Practice: Y N P Quality of significant relationship: _____
Hobbies: _____
History of sexual, mental/emotional, physical abuse: Y N P If so, at what age and by whom?
_____
How committed are you towards making valuable changes? Little Moderately Very
Have you lived/visited outside of the country such as India, Mexico, Africa, etc.? Y N

TYPICAL DAY'S DIET

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks:
_____
_____

Beverages: Coffee _____
Tea _____
Sodas _____
Water _____, How much? _____

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Patient Name: _____

LIST OF DOCUMENTS TO SUBMIT PRIOR TO OR AT YOUR INITIAL OFFICE VISIT

1. All pathology reports
2. Up to five of your most recent lab results if available
3. Up to three of your most recent imaging studies (such as CT, bone scan, P.E.T., x-rays) if available.
4. Surgical or operative reports
5. List of ALL supplements and medications you are currently taking with dosages

Please list any birth control used, type and ages used:

_____

_____

Please list any hormone replacement therapy used, type and ages used:

_____

_____

	Supplement or Medicine	Dosage	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			