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): _______

	Father		Mother		Siblings		Grandparents	
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	Sexual Orientation	Hetero 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
Sexual Orientation	Hetero Homo Bi	If yes, what were results	________
		Thermography	Y N P
		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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INITIAL HISTORY FORM

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			