eimc
ENDOBIOGENIC INTEGRATIVE MEDICAL CENTER

Health History Follow-up Questionnaire

Today's Date: _____ **(F) Current Status**

Name		Date of Birth	
		Height:	Weight:

What symptoms or conditions are you seeking help with?	Clinician's Notes
If this is a follow-up visit for your problem(s), would you say you're doing better, worse, or about the same as before?	
Have you undergone any testing elsewhere? (please note)	
Have you had any treatments elsewhere? (please note)	
Have you received any new diagnoses? (please note)	
What medications, herbs and supplements are you currently taking?	
Have you had any problems or side-effects from any of the above?	
Do you have any new drug allergies? (please note)	

(TURN OVER)

6000 S 5th Ave. Phone: 208-478-8400 Fax: 888-592-0567 info@eimcenter.com

Pocatello ID 83204 Phone: 877-470-8400 Fax : 888-653-5091 TOLL FREE www.eimcenter.com

EIMC Patient History – Page 2

Please note any other changes to your health since you were last seen here.	Clinician's Notes
Please note any important changes to your family, job, income, good habits or bad habits since you were last seen here.	
How would you rate your current stress level on a scale of 0-10?	

When was your last menstrual period?		
Was it normal?		

Review of Systems: Please check any symptoms you have been having recently

		Headaches			Joint pain			Dizziness
		Vision changes			Muscle pain			Fatigue or weakness
		Sore throat			Neck or back pain			Shaking or tremor
		Nose congestion			Fever or chills			Depression
		Trouble breathing			Hot flashes			Anxiety or easily startled
		Chest pain			Sweats			Mood swings
		Irregular heart beat			Weight loss			Irritable mood
		Abdominal pain			Weight gain			Sexual dysfunction
		Diarrhea			Hair loss			Easy bruising
		Constipation			Brittle nails			Rashes
		Bloating			Excess body hair			Dry skin
		Nausea or vomiting			Menstrual irregularities			Acne
		Urinary disturbances			Heavy bleeding			New moles

Please sign		**Date**	
Reviewed by		**Date**	

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