eimc
ENDOBIOGENIC INTEGRATIVE MEDICAL CENTER

Endobiogenic Health History Questionnaire

Last Name:		First Name:		M. Initial:		Current Date:	
Address:		SSN (no dashes):		Birth Date:			
City:		State:		Zip:		email:		Phone:	
Spouse or Next of Kin		Height (inches)		Weight (lbs)		Blood Pressure	

Primary Care Physician:	Name		Phone:		Fax:	
	Address		City		State		Zip Code	

Please explain your goal in obtaining an Endobiogenic evaluation by answering the following questions:

What symptoms are bothering you?

How have these problems been evaluated and addressed in classical medicine?

a) What tests have been done?

b) What Diagnosis have you been given?

c) What treatments have been recommended or tried?

Physician Notes

Past health history / developmental history:

Weight at Birth		Length at Birth		Full term?		If not, how many days early		or days late?	
Hair on Head at birth?		If yes, what color?		Did your mother have a stressful pregnancy with you?					
Where you breast fed?		How Long?							
Temperament as a child?									
Calm or stressful childhood?									
Was you childhood growth fast, slow, or average?		Was your weight gain fast, slow, or average?							

Physician Notes

Childhood illness or trauma:	
Adult illness including dates:	
Important psychological traumas in your lifetime?	
Surgeries, pregnancies (including miscarriages), transfusions, other hospitalizations & dates:	
Past medications taken on a regular basis and adult vaccinations and dates:	
Medications, herbs, or supplements you are currently taking:	
Allergies to drugs (describe the reaction):	

Physician Notes

Past and present lifestyles / habits:

Household Includes:			
Ever drink alcohol? How much and how often?			
Ever use tobacco? How long and how often?			
Ever use recreational drugs? What and when?			
Special Diet? Which kind?			
Excercise?			
Current Occupation:		Past Occupation:	
Travel Outside the U.S.?			
Currently married?		How long?	
Prior marriages?			
Children?		Dates of births:	
Pets?			
Overall adulthood stress level on a scale from 1 (low) to 10 (high)?			
Current stress level on above scale:			
What are your main sources of stress?			
Who provides you with emotional support?			

Physician Notes

Screening test When did you have any of the following tests (if applicable)?

Bowel cancer screening (if over 50)?	
Cervical cancer screening (pap smear, etc.)?	
Breast cancer screening (mammogram, exam)?	
Cholesterol level?	Other?

Family History:

What is your ethnic heritage?		Are your parents still living?	

Any history in blood relatives of:

	Cancer		Dementia		Heart Disease
	Diabetes		Depression		Hypertension
	Arthritis		Stroke		Other:

Review of systems:

Do you sleep well at night?		How many hours on average?		Do you have trouble falling asleep?		staying asleep?	
When do you wake at night?		Do you remember your dreams?		Are they in color?			
Do you hear sounds or conversations in your dreams?		Do you have unusual dreams or nightmares?					
Do you tend to take a nap during the day?							
Are your PALMS generally		and		Are your FEET generally:		and:	
Is your appetite generally:		Are the meals that you eat generally:		Which do you prefer more:			
What amount of fluids do you tend to drink?:		Are you hungry when you wake up in A.M.?		Is your mouth usually more:			

Do you have any of the following? (In the blank, place a C for CURRENT problems and an F for frequent PAST problems.)

	fatigue		breast pain/discharge		muscle pain		urinary problems
	frequent headaches		cough		joint pain		weight gain or loss
	neck pain		difficulty breathing		back pain		frequent infections
	teeth grinding		abdominal pain		skin color changes		fever, chills, sweats
	enlarged tonsils/glands		appetite disturbance		dry skin		easily startled
	nasal congestion		nausea		eczema or rashes		easily brought to tears
	sore throat		vomiting		new moles		anxiety
	environmental allergies		excess belching or gas		acne or boils		depression
	chest pain		diarrhea		hair loss		sexual dysfunction
	heart palpitations		constipation		excess hair growth		memory disturbance
	heartburn		hemorrhoids		brittle nails		easy bruising

Completed by:		Date:	

Physician Comments:	

Reviewed by:		Date:	

(Women Only)

Date of last menstrual period?	
Age of first menses?	
Days between menses (from first day to first day)?	
Length of menses?	
Any clotting or heavy bleeding?	Which days?
Any cramping?	Which days?
PMS symptoms if any?	
If breast pain/tenderness, where in breasts, and how many days?	
Do you often have an abnormal vaginal discharge?	

Additional questions:

Did you have acne during adolescence?	Mild	Moderate	Severe
Do you have problems with excess hair growth on your face or body?	Where?		
Have you removed any hair through shaving	plucking	waxing	or electrolysis?
How often do you shave your legs in the summer?			
Have you had any other cosmetic treatment done such as botox or surgery?			

If applicable:

What are you using for contraception?	
What have you used in the past for contraception?	

If applicable (regarding pregnancies):

Any miscarriages?	
Any pre-term deliveries or overdue deliveries?	
Any pregnancy complications such as high blood pressure or blood sugar?	
Any other stress during pregnancy?	
Length of labors?	
Any complications of delivery?	
Did you breast-feed your children?	How long?

If applicable:

Age of menopause?	
Menopausal symptoms?	

Physician Comments:	

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