eimc
ENDOBIOGENIC INTEGRATIVE MEDICAL CENTER

Health History Follow-up Questionnaire

(M) Today's Date: _____

Name		Date of Birth	

Current Status **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)	

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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?	

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

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

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