



HEALTH HISTORY & BACKGROUND INFORMATION

Completing this form prior to your appointment allows more time for discussion with your provider.

NAME: _____ Age: _____ Date: _____

- 1. What is your overall goal(s) in coming to IMC?
- 2. Will you be having your primary care at IMC? Yes Don't know yet
 No -- Who is your primary physician? _____
- 3. Do you have a Durable Power of Attorney for Health Care? No Yes: Who is it? _____
- 4. Who lives with you in your home? _____

MEDICAL HISTORY

- 5. What do you consider your greatest health asset:
- 6. What do you consider your greatest health problem:
- 7. DO YOU HAVE any of the following conditions? Are you under a doctors' care? Who?
 - Cancer: Which type of cancer: No Yes _____
 - Heart Disease..... No Yes _____
 - Diabetes..... No Yes _____
 - High Blood Pressure..... No Yes _____
 - Headaches..... No Yes _____
 - Neurological conditions..... No Yes _____
 - Kidney/urinary problems..... No Yes _____
 - Stomach, GI, problems..... No Yes _____
 - Depression..... No Yes _____
 - Experienced violence or abuse..... No Yes, When: _____
 - Other _____

Women: Number of Pregnancies _____ Live Births: _____ Living Children/ ages _____
Complications during pregnancy or delivery? _____

8. Past Surgeries/Hospitalizations? Please give reason and estimated dates:

9. Known Allergies to Medications: _____



10. Smoke: Never Stopped: ____ Years/Months Smoke Free Yes: ____ Years ____ packs/ day

11. How often do you consume alcohol: _____ What Type: _____

12. Current list of Medicines, Vitamins, Herbs, and/or Supplements with doses:

13. What is/was your occupation? _____

14. Do you have FAMILY MEMBERS with any of the following:
Heart disease, high blood pressure, stroke or diabetes
Colon cancer Breast or Ovarian Cancer Melanoma skin cancer
History of alcohol or drug addiction History of violence or abuse

15. Do you: Wear your seat belt? ____ Have working smoke detectors in your home? ____
Have guns in the home? ____ Practice safe sex? ____

16. How often do you exercise? ____ times per week ____ minutes at a time

17. How many meals per day do you usually eat? _____ At what times: _____
How many glasses of water do you usually drink per day? _____

18. Please describe a scenario when you would know you are well and meeting your health goals:

19 . Please review the list below:

Activity Have used in past Worked well for me Would like to try

- Chinese Medicine.....
- Acupuncture.....
- Massage.....
- Chiropractic.....
- Nutrition.....
- Energy work.....
- Naturopathic Medicine.....
- Feldenkrais.....
- Tai Chi /Chi Gung.....
- Herbs, supplements.....
- Biofeedback.....
- Counseling/therapy.....

Other things we should know: _____



INTEGRATIVE
MEDICAL CLINIC
OF SANTA ROSA