HEALTH INVENTORY FORM

NYC | WORLD

Name (First Name and Last Initial ONLY) _________________ Date _________________

Occupation ____

Education ____

Date of Birth ________________ Age _________ Gender _______________________

How did you hear about AHE NYC | World Student Clinic?

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Family History

Age — If passed, cause of death

Father ____

Mother ____

Siblings ____

Children ____

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Check **Items that apply to blood relatives, and list relationship.**

Alcohol/drug problem
Allergy/Asthma
Anemia
Arteriosclerosis
Arthritis
Binge Eating/Bulimia
Bleeding Problem
Cancer
Diabetes
Epilepsy/seizure
Heart Disease
Skin Disease
Gonorrhea

High Blood Pressure
High Cholesterol
Kidney Disease
Liver Disease
Mental Illness
Obesity
Stroke
Suicide
Thyroid Disease
Tuberculosis
Ulcer
Syphilis

Please list approximate dates of any that apply**.**

Acne	Endometriosis	Nightmares
AIDS	Fibroids (uterine)	Overweight
Alcohol/drug problem	Gallbladder	Panic Attack
Allergies	Glaucoma	Pelvic Infection
Anemia	Gout	Periodontal Disease
Antibiotics (1x a year)	Hearing Problems	Phlebitis
Anorexia/Bulimia	Heart Attack	Pneumonia
Anxiety	Heart Failure	Premenstrual Tension

Arthritis	Hemorrhoids	Prostrate Problems
Asthma	Hepatitis	Psychotherapy
Back Problems	Herpes	Rheumatic Fever
Binge Eating	Hernia	Scarlet Fever
Bladder infections	High Blood Pressure	Seizures/epilepsy
Blood clots	High Cholesterol	STI's
Breast lumps	Hives	Sinusitis
Bronchitis	Insomnia	Sleep Disorder
Cancer	Kidney Infection/stones	Steroid Use
Cataract (s)	Liver Disease	Stroke
Chemical Sensitivity	Menstrual Problems	Suicide Attempt
Chronic Fatigue	Mental Illness	Syphilis
Colitis	Migraine	Thyroid Problem
Depression/Anxiety	Mononucleosis	Tuberculosis
Diabetes	Mumps	Ulcer
Ear Infection	Neurological Problem	Vaccine Reaction
Eczema		Warts

Surgery: List all procedures and approximate dates	**Hospitalizations**: Reasons/Dates
Accidents, Traumatic Injuries, Broken Bones:	**Current Health Problem/Diagnosis:**

Male	**Female**
Enlarged prostate?	Date of last menstrual period:
Decreased urine stream?	Length of cycle
Unable to interrupt stream?	Length of period
Dribbling after urination?	Age menstruation began:
Pus or drainage from penis?	Menopause?
Genital swelling?	Number of pregnancies
Rash/eruptions?	Number of live births
Problems with sexual function?	Number of abortions/miscarriages
	Vaginal discharge?
	Spotting between periods?

	Painful intercourse? Issues with fertility? Problems with sexual function?

Lifestyle

Prescription Medications (List prescribing doctor)	**Vitamins/Mineral Supplements**
Allergies	**Food Allergies (include method of testing)**
Food Cravings	**Alcohol/Recreational Drug Use** Do you drink alcohol or use drugs? How much/often?

Caffeine Do you drink coffee or tea? How much/often?	**Cigarettes** Do you smoke now or did you in the past? How much/often?
Diet Soda/Artificial Sweeteners Describe your use:	**Refined Sugars/Processed Foods:** Describe your use:
Hobbies How often do you do them?	**Living Situation**

Exercise: Describe the ways you get your body moving. Do you feel you get enough physical activity?	**Food:** Do you feel you eat a healthy and well-balanced diet? Do you need guidance/support?

Worry/Anxiety: Do you have particular issues that worry you? How does this impact your life?	**Healthy Relationships:** Do you have a supportive family/community?
Unhealthy Relationships: Have you been a victim of domestic abuse or troubling relationships?	**Spiritual Life:** Do you have a spiritual practice? Is your spiritual life fulfilling and satisfactory?
Intimacy: Are you satisfied with your sexual/intimate life?	**Anything else?** Please indicate any topics you want to address in your consultation.

Life Changes

In the past year, what changes have occurred in your:

Personal Life:
Family Life:
Social Life:
Work Life:
Sex Life: