DR. LESLIE YEDOR
INTEGRATIVE MEDICINE

Health History

Patient Name: Date:

Chief Complaint(s):

What brings you in today?	
When did this being?	
Who else have you seen, and what have you tried for this condition? (Provider, diagnosis, treatments…)	

PLEASE INDICATE IF ANY OF THE FOLLOWING HAVE BEEN PART OF YOUR **PRESENT OR PAST** HEALTH HISTORY:

HEALTH CONDITION	**SELF** (date of onset & present status if applicable)	**FAMILY MEMBER** (specify when applicable)
Addiction		
Anemia		
Asthma, Seasonal Allergies, or Hayfever		
Autoimmune Disorder (specify)		
Bleeding or Clotting Disorder		
Blood Clots		
Bone Fractures		
Cancer (specify)		
COPD		
Diabetes (specify type 1 or 2)		
Epilepsy		
Heart Disease or Heart Attack		
Hepatitis (specify type A B C D E)		
HIV+ or AIDS		
Hypertension / High Blood Pressure		
Hypotension / Low Blood Pressure		
Hypoglycemia		
Immune Compromised		
Implants or Prosthetics		
Mental Illness		
Osteoporosis/Osteopenia		
Pregnancy (live birth or miscarriage)		
Pacemaker / Defibrillator		
Sensory Loss (specify)		
Spinal Injury		
Stones (kidney, gallbladder…)		
Stroke		
Thyroid Disorder (specify)		
Tuberculosis		

Reviewed by: Date:

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Patient Name:	Date:

List any hospitalizations or surgeries:	Approximate Dates:

List any known allergies or sensitivities (food, medications, supplements, herbs, environmental, or otherwise)

MEDICATIONS & SUPPLEMENTS

Please list any current prescribed, over-the-counter, and/or dietary supplements or herbs taken (attach a separate sheet if necessary)

Medication / Supplement / Herb	Dosage/How Often:	Prescribing Physician/Reason for Taking

RECENT HEALTH HISTORY & REVIEW OF SYSTEMS

Please check any symptoms or activity you CURRENTLY experience or have experienced recently (in the past 6 months)

General, Constitutional, & Psychosocial:

☐ Anxiety ☐ Depression ☐ Dizziness ☐ Emotional Symptoms Worse at Night ☐ Indecisiveness ☐ Irritability ☐ Nightmares ☐ Panic Attack ☐ PTSD ☐ Restlessness ☐ Fatigue ☐ Fever ☐ Headache ☐ Insomnia ☐ Night Sweat ☐Frequent Sweat ☐ Memory Loss ☐ Weight Loss ☐ Weight Gain

Cardiovascular & Pulmonary:

☐ Angina ☐ Asthma ☐ Bronchitis ☐ Bruise Easily ☐ Chest Pain ☐ Cough ☐ High Cholesterol ☐ Irregular Heartbeat ☐ Leg Cramps ☐ Palpitations ☐ Pneumonia ☐ Shortness of Breath ☐ Frequent Sighing or Yawning ☐ Snoring or Sleep Apnea ☐ Swelling (legs, ankles, feet, hands) ☐ Varicose Veins ☐ Wheezing

Head, Eyes, Ear, Nose & Throat:

☐ Changes in Vision ☐Corrective Lenses ☐ Diminished Hearing ☐ Double Vision ☐ Dry Mouth ☐ Dry Eyes ☐ Ear Ache ☐ Eye Twitch ☐ Frequent Colds ☐ Hair Loss ☐ Itchy Eyes ☐ Loss of Smell ☐ Light Sensitivity ☐ Noise Sensitivity ☐ Nosebleed ☐ Red or Burning Eyes ☐ Ringing / Tinnitus ☐ Runny Nose ☐ Sinus Infection ☐ Sore Throat ☐ Vertigo ☐ Watery Eyes

Gastrointestinal:

☐ Abdominal Pain ☐ Acid Reflux ☐ Black/Tarry Stool ☐ Bloating ☐ Bitter Taste ☐ Constipation ☐ Diarrhea ☐ Excess Hunger or Thirst ☐ Gas ☐Hemorrhoids ☐ Indigestion ☐ Jaundice ☐ Loss of Taste ☐ Low Appetite ☐ Nausea ☐ Trouble Swallowing ☐ Ulcer ☐ Undigested Food in Stool ☐ Urgent Stool ☐ Vomiting

Musculoskeletal & Neurological:

☐ Arthritis ☐ Bone Pain ☐ Bone Spur ☐ Bunion ☐ Joint Pain ☐ Concussion ☐ Fainting or Lightheadedness ☐ Fibromyalgia ☐ Gout ☐ Limited Range of Motion ☐ Muscle Pain ☐ Muscle Weakness ☐ Nerve Pain ☐ Numbness or Tingling ☐ Paralysis ☐ Poor Balance ☐ Seizures ☐ Stiffness ☐ Tics ☐ Tremors

Skin & Lymphatic

☐ Acne ☐ Cysts ☐ Change in Moles or Growths ☐ Dry Skin / Hair ☐ Eczema ☐ Hives ☐ Itching ☐ Lumps ☐ New Moles or Growths ☐ Psoriasis ☐ Rashes ☐ Sensitive Skin ☐ Swelling ☐ Swollen Lymph Nodes ☐ Tender Lymph Nodes

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RECENT HEALTH HISTORY & REVIEW OF SYSTEMS CONT.

Urinary & Reproductive

☐ Amenorrhea ☐ Breast Pain ☐ Discharge ☐ Dysmenorrhea / Painful Menses ☐ Erectile Dysfunction ☐ Heavy Menstruation ☐ High Libido ☐ Low Libido ☐ Infertility ☐ Irregular Menses ☐ Menopause Age:_____ ☐ Miscarriage ☐ PCOS ☐ PMS ☐ Prostate Issues ☐ Spotting ☐ STI ☐ Blood in Urine ☐ Burning or Painful Urination ☐ Change in Urinary Frequency ☐ Difficult or Hesitant Urination ☐ Hernia ☐ Nocturnal Urination ☐ Urinary Urgency

Habits & Cravings

☐ Cigarette Smoking ☐ Alcohol _____ drinks per week ☐ Recreational Drugs ☐ Caffeine ☐ Sugar ☐ Soft Drinks ☐ Salt ☐ Fried or Fast Food ☐ Other:_____ ☐ Preference for cold food / drink ☐ Preference for warm food / drink ☐ Thirsty with no desire to drink ☐ Hungry with no desire to eat ☐ Hungry or thirsty at night

Dietary Habits:

List any dietary restrictions (vegetarian, vegan, gluten free, dairy free, etc...):

Describe your typical breakfast:

Describe your typical lunch:

Describe your typical dinner:

Describe your typical snacks and/or desserts:

Is there anything else you would like me to know about your health history?

The above information regarding my medical history is, to the best of my knowledge, complete and accurate. I agree to promptly notify Dr. Leslie Yedor, DAOM, L.Ac., of any changes in my health status and/or additional medical history.

Patient Signature:_____ Date:_____

Guardian or Interpreter's Signature:_____ Date:_____

Reviewed by: Date:

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