Confidential Patient History

Legal Name _____Name you preferred to be called _____

Address _____ City _____ State _____ Zip _____

Home (_____)_____ Work (_____)_____Mobile (_____)_____

Sex Male ☐ Female ☐ Age _____ DOB _____ Social Security _____-_____-_____

Email _____

Occupation _____ Employer _____

Names/Ages of Children _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other_____

Name of Partner _____ Partner's Employer _____

Name of Emergency Contact _____ Relationship _____

Best Number to Contact Them ☐ Mobile ☐ Home ☐ Work ☐ Other (_____) _____

How did you hear about Dr. Bloink?_____

Do you have health insurance? ☐ Yes ☐ No If you checked yes, please provide us with a copy of your insurance ID card(s).

Name of the insured_____ Insured's date of birth_____

What is their relationship to you? ☐ Spouse ☐ Child ☐ Other_____

Do they live at the same address as you? ☐ Yes ☐ No

If you checked no, what is their address_____City_____ State_____

Zip _____ Phone Number (_____) _____

Nutritional & Metabolic Evaluation
Please complete the following information as completely as possible. This helps us to address your concerns and needs, and to build a health program personally designed for you.

Complaints | Please rank your health complaints and rate their severity (on a scale from 1-10, 10 being the worst).

_____
_____
_____
_____

Other Information | Please tell us any additional information or concerns about your health.

_____
_____
_____

Goals | What are your goals for seeing Dr. Bloink?

_____

Limitations | What limitations do you have, if any, in working with Dr. Bloink? (e.g. unwilling to take nutritional supplements, working in excess of 60 hours a week, won't give up smoking or alcohol, etc).

_____

Stress Level | Rate your stress level currently on a scale from 1-10 (10 being the most stress). Note that stress can come in forms such as overwork, relationships, health concerns, tiresome family or work responsibilities, excessive fear, worry, anxiety, insomnia, road rag e, not happy with life, depression, etc.
Overall stress:_____ Main reasons for stress_____
_____
If over a level 5, what steps are you currently taking to reduce your stress?
_____

Energy Level | List on a scale from 1-10 (1 is lowest, 10 is highest) what is your energy level during the following times:
AM _____ Afternoon _____ Evening _____ Late PM _____ After meals _____ Overall _____

Sleep Quality | How is your sleep? (check all that apply) ☐Restful ☐Restless ☐Hard to get sleep ☐Wake up often ☐Nightmares
What time do you usually go to sleep? _____ Hours of sleep/night? _____
Type of mattress? _____ How old is it? _____ Type of pillows, sheets, and blankets? _____

Exercise | Do you exercise? _____ How often? _____ For how long per session? _____
What type of exercise do you do? _____

Medical History | Please describe any conditions which are under the care of a physician.
Diagnosis _____
Date of onset _____ Duration of current symptoms _____
Doctor(s) involved, their specialty _____
How diagnosed (what tests)? _____
Current treatment (medication, etc.) _____
Treatment received in past, if any, and how it worked _____

Medications | Please list any medications you are taking, or have taken in the past, and for how long. State the reason for taking it.

☐ Antacids	☐ Anti-inflammatory	☐ Diuretics	☐ Muscle Relaxers	☐ Steroids (prednisone, anabolic, cortisone)
☐ Antibiotics	☐ Birth Control Pills	☐ Hormones (estrogen, progesterone, DHEA, testosterone, thyroid)	☐ Pain Killers	
☐ Antidepressants	☐ Blood Pressure Meds		☐ Parasite Medication	☐ Yeast/Fungal Meds
☐ Antihistamines	☐ Cardiac/Heart Meds			

_____
_____

Drugs | This is strictly confidential. Please list any recreational drugs used now or in the past: _____
_____ How often? _____ How long? _____

Surgeries/Hospitalizations | What surgeries, operations, traumas, fractures, car accidents, etc. have you had?

☐ Appendectomy	☐ Breast Implants	☐ C-Sections	☐ Plastic or metal inside your body	☐ Implants/Prostheses
☐ Arthroscopy	☐ Biopsies	☐ D&Cs		☐ Laparoscopy
☐ Cosmetic Surgery	☐ Body piercings		☐ Eye Surgery	☐ Tonsils/Adenoids

Other (please list all with brief details such as date, outcome, etc.) _____
_____
_____

Scars | Describe any scars on your body (major and minor ones) _____

Smoking | Do you currently smoke? _____ How much? _____ How long? _____

Dental Work | Indicate how many of the following you have:

☐ Silver fillings _____	☐ Composites _____	☐ Bleeding gums _____	☐ Dentures _____	☐ Porcelain crowns ____
☐ Root canals _____	☐ Grinded/worn teeth _____	☐ Veneers _____	☐ Sensitive teeth _____	☐ Gold crowns _____
☐ Extractions _____		☐ Posts _____	☐ Temporaries _____	☐ Steel crowns ____
☐ Implants _____	☐ BioCalex root canals_____	☐ Extractions _____	☐ Infections/pockets ___	
		☐ New cavities _____		

Do you need further dental work? _____ If so, what? _____

Sunlight | Amount of natural sunlight you receive daily outside? _____
Hours spent daily under fluorescent light? _____ Hours of sunlight daily through windows? _____

Clothing | How often do you wear 100% natural clothing (cotton, ramie, wool, silk, linen)? _____
How often to you wear 100% synthetic clothing (polyester, acrylic, nylon, rayon, etc.)? _____ Blends? _____

Family History | Check those that apply and indicate the outcome and age of onset.

	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Mother	Father	Brother	Sister	Onset	Outcome
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Arthritis (type)	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Cancer (type)	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Mental Disease	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Thyroid Imbalance	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____

Other _____

Review of Systems | Please check the " NOW " box for all conditions that you are now experiencing and mark the "PAST" box for any condition or symptoms experienced at any time in your life.

General			**Nose**			**G-I System**			**Neurologic**			**Conditions**		
Weight loss	☐	☐	Nosebleeds	☐	☐	Gas	☐	☐	Seizures/Epilepsy	☐	☐	Hypertension	☐	☐
Weight gain	☐	☐	Sinus problems	☐	☐	Heartburn	☐	☐	Strokes	☐	☐	Diabetes	☐	☐
Head			**Lungs**			Indigestion	☐	☐	Tingling sensation	☐	☐	Thyroid condition	☐	☐
Headache	☐	☐	Difficulty breathing	☐	☐	Ulcers	☐	☐	Numbness	☐	☐	Heart condition	☐	☐
Dizziness	☐	☐	Asthma	☐	☐	Vomiting/Nausea	☐	☐	Weakness	☐	☐	Rheumatic arthritis	☐	☐
Head trauma	☐	☐	Pneumonia	☐	☐	Abdominal Pain	☐	☐	Difficulty walking	☐	☐	Rheumatic fever	☐	☐
Fainting	☐	☐	Wheezing	☐	☐	Diarrhea	☐	☐	Poor coordination	☐	☐	Glaucoma	☐	☐
Blacking out	☐	☐	Persistent cough	☐	☐	Constipation	☐	☐	**Muscle/Bone**			Alcoholism	☐	☐
Eyes			Coughing phlegm	☐	☐	Blood in stool	☐	☐	Joint pain	☐	☐	Cancer/Tumor	☐	☐
Change in vision	☐	☐	Coughing blood	☐	☐	Hemorrhoids	☐	☐	Stiffness	☐	☐	Polio	☐	☐
Cataracts	☐	☐	Tuberculosis	☐	☐	Gall bladder disease	☐	☐	Muscle ache	☐	☐	Parkinson's	☐	☐
Light sensitivity	☐	☐	**Vascular**			Liver disease	☐	☐	Arthritis	☐	☐	Multiple Sclerosis	☐	☐
Flashes in vision	☐	☐	Chest pain	☐	☐	**G-U System**			Bone pain	☐	☐	Gout	☐	☐
Spots in vision	☐	☐	Palpitations	☐	☐	Difficulty urinating	☐	☐	Fractures	☐	☐	Anemia	☐	☐
Mouth			Ankle swelling	☐	☐	Pain urinating	☐	☐	Dislocations	☐	☐	Osteoporosis	☐	☐
Bleeding gums	☐	☐	Cold feet/hands	☐	☐	Blood in urine	☐	☐	**Skin**			Osteoarthritis	☐	☐
Cold sores	☐	☐	Leg cramps	☐	☐	Incontinence	☐	☐	Rash	☐	☐	High cholesterol	☐	☐
Dentures	☐	☐	Calf pain	☐	☐	Foul odor of urine	☐	☐	Bruising	☐	☐	Migraines	☐	☐
Sore throat	☐	☐	Varicose veins	☐	☐	Increased urination	☐	☐	Brittle nails	☐	☐	TIAs	☐	☐
Jaw pain	☐	☐	Low blood pressure	☐	☐	Decreased urination	☐	☐	Changes in moles	☐	☐	Headache unlike	☐	☐
Changes in taste	☐	☐	High blood pressure	☐	☐	Urinary infection	☐	☐	Itching	☐	☐	any previously		
Hoarseness						Genital infection	☐	☐	Peeling	☐	☐	experienced		

Bowel Movements | Please circle those that apply.
How often: daily | more than once a day | skip days Consistency: normal | too hard | too soft | diarrhea alternating with hard
Amount: normal | too little Color: brown | black | yellow | whitish Other: mucus | foul smell | lots of gas
Comments:_____

Female Specific Issues | Please circle those that apply and fill in the blanks.
Are you pregnant? Y N Going through menopause? Y N Have your periods stopped? Y N
Breast feeding? Y N Are your periods regular? (28 day cycle) Y N Do you have monthly periods? Y N
Date of your last menstrual period? _____ Have you had a hysterectomy (indicate date, partial or total):
_____

Emotional Tendency | Please check those emotions that you have a tendency towards.
☐ Anger ☐ Anxiety ☐ Criticism ☐ Fear ☐ Insecurity ☐ Worry ☐ Inability to forgive (self/others) ☐ Other _____

Toxic Inventory / Personal Care Products | Please list any toxins, chemicals, or solvents you have had exposure to or use of. These can include products for the yard, work, furniture, art, building/carpentry, etc. (list the brand names in the space provided):

☐ Shampoo _____ ☐ Deodorant _____ ☐ Toothpaste _____
☐ Body Soap _____ ☐ Hand/Body Lotion _____ ☐ Laundry Soap _____
☐ Dish Soap _____ ☐ Household Cleaner _____ ☐ Hairspray/Gel _____
☐ Nail Polish _____ ☐ Hair Coloring _____ ☐ Air Freshener _____
☐ Ant/Roach Spray _____ ☐ Pesticides _____ ☐ Other _____

Electromagnetic Exposure | How many hours do you spend daily:

☐ Watching TV _____ ☐ Talking on a cell phone _____ ☐ Near electrical equipment _____
☐ Wearing a pager _____ ☐ Working on a computer _____ ☐ Sleeping near an electric clock? ____

Water/Hydration | How many glasses (8-10 oz) of plain water do you drink in an average day? ___ Do you drink tap water? ___
What brand(s) of drinking water do you use? _____
Do you cook with tap, bottled, or filtered water on a regular basis? _____
If you have a home water purifier, when was the last time you changed the cartridge? _____

Diets | Please check any applicable diet that you are currently on.

☐ Allergy rotation/desensitization ☐ No dairy ☐ Vegetarian ☐ Vegan ☐ Yeast-free ☐ Low fat ☐ Diabetic ☐ Any other diet _____
☐ Atkins/Zone diet ☐ Candida diet ☐ Low salt

Food Habits | How often do you eat out, and at what type of restaurants? _____
How often do you prepare meals at home? _____ Do you avoid food/drinks that list "natural flavors" on the label? _____
Please check if you do any of the following:
☐ Eat while working, watching TV, driving, etc. ☐ Eat food past 7pm ☐ Eat/chew food too fast ☐ Skip meals often (which ones) _____

Food Choices | Please check each type of food you eat twice a week or more. (C=commercially grown, O=organically grown)

Premade Foods		**Harvest**		**Meat/Fish**		**Dairy**		**Condiments**	
Canned foods	☐ ☐	Fresh vegetables	☐ ☐	Beef, pork, lamb	☐ ☐	Eggs	☐ ☐	Table salt	☐ ☐
Boxed cereal	☐ ☐	Fresh fruit	☐ ☐	Chicken	☐ ☐	Butter	☐ ☐	Sea salt	☐ ☐
Frozen dinners	☐ ☐	Whole grains	☐ ☐	Turkey	☐ ☐	Milk	☐ ☐	Ketchup	☐ ☐
Frozen juices	☐ ☐	Whole beans	☐ ☐	Canned tuna	☐ ☐	Milk, raw	☐ ☐	Mustard	☐ ☐
Take-out food	☐ ☐			Fresh fish	☐ ☐	Cheese	☐ ☐	Vinegar	☐ ☐
				Frozen fish	☐ ☐			Sweetener	☐ ☐
				Restaurant fish	☐ ☐				

Food Stressors |Please check which of the following you have every week & indicate how many times per week you consume it.

Stimulants		**Toxic Oils**		**Hormone Platters**		**Empty/Processed**	
				(non-organic)			
Coffee (inc. decaf)	☐___	Fried foods	☐____	Beef	☐____	White pasta	☐____
Black tea, chai tea	☐___	Fast foods	☐____	Chicken	☐____	White bread	☐____
Soft drinks (cola, etc.)	☐___	Potato or corn chips	☐____	Milk, Ice cream	☐____	Instant cereal	☐____
Drinks w/NutraSweet	☐___	Roasted nuts	☐____	Cheese, butter	☐____	Cookies	☐____
Alcohol	☐___	Smoked meats	☐____	Yogurt	☐____	Store-bought muffins	☐____
Chocolate	☐___	Margarine	☐____	Hot dogs/sausage	☐____	Minute rice	☐____
Candy, pastry, sweets	☐___	Shortening	☐____	Pork, lunch meats	☐____	Bagels	☐____

Signature_____ Date_____

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