

Dr. Richard E. Picard

Advanced Nutrition

Name: _____ Date: _____ File # _____

Confidential Health History

The items below may relate to your current condition. Mark (Y) if any of the following items pertain to you or leave it blank if none of these items are associated with your current level of health.

General Health Status

- _____ Loss of sleep
- _____ Fatigue
- _____ Weight gain or loss
- _____ Fever
- _____ Chills
- _____ Nervousness
- _____ Night Sweats
- _____ Allergies
- _____ Anemia
- _____ Diabetes
- _____ Cancer
- _____ Thyroid Disease
- _____ Heart Disease
- _____ HIV (AIDS)
- _____ Hepatitis A, B or C
- _____ Epstein Barr Virus (Mono)
- _____ Root Canal
- _____ Lyme disease (tick-bite)

ENT

- _____ Poor Vision
- _____ Eye Disease
- _____ Hearing Problems
- _____ Ear Infections
- _____ Sinus Problems / Infections
- _____ Dental Problems
- _____ Hoarseness
- _____ Sore Throat
- _____ Tonsillectomy

Gastrointestinal

- _____ Poor digestion or appetite
- _____ Difficulty swallowing
- _____ Current Nausea
- _____ Stomach or abdominal pain
- _____ Ulcer or GERD
- _____ Liver Disease
- _____ Gall bladder removed / stone
- _____ Diarrhea or Constipation
- _____ Celiac Disease (gluten)
- _____ IBS, Diverticulitis, Chron's
- _____ Jaundice
- _____ Hernia
- _____ Hemorrhoids
- _____ Appendicitis

Respiratory

- _____ Difficulty breathing
- _____ Chronic cough
- _____ Asthma
- _____ Bronchitis
- _____ Pneumonia
- _____ Tuberculosis
- _____ Excessive phlegm
- _____ Emphysema
- _____ Spitting up blood

Cardiovascular

- _____ Irregular heart beat
- _____ High blood pressure
- _____ Stroke
- _____ Previous heart trouble
- _____ Ankle swelling
- _____ Artery disease
- _____ Rheumatic fever
- _____ Pacemaker

Skin

- _____ Acne
- _____ Bruising easily
- _____ Itching
- _____ Psoriasis / Eczema
- _____ Hives / Rashes
- _____ Melanoma or new growth

Men Only

- _____ Prostate problems
- _____ Low Testosterone
- _____ Testicular problems
- _____ Urinary problems

Women Only

- _____ Painful periods
- _____ Irregular cycles
- _____ PMS
- _____ Menopause / Hot flashes
- _____ Birth control pill
- _____ Urinary / Yeast Infections
- _____ Hormone Therapy
- _____ Hysterectomy
- _____ Breast augmentation

Neurologic

- _____ Headache
- _____ Dizziness
- _____ Fainting
- _____ Weakness
- _____ Numbness or tingling
- _____ Burning sensation
- _____ Arm or Leg pain
- _____ Psychological disorder
- _____ Neurological disease
- _____ Epilepsy / Seizures

Musculoskeletal

- _____ Neck pain or stiffness
- _____ Back pain or stiffness
- _____ Joint pain or stiffness
- _____ Swollen Joints
- _____ Muscular pain or stiffness
- _____ Arthritis
- _____ Scoliosis / spinal curvature

Exercise

- _____ None
- _____ Less than 3X per week
- _____ More than 3X per week

Habits

- _____ Smoking
- _____ Drinking (socially / binge)
- _____ Recreational drug use

Family History

- _____ Heart Disease
- _____ High Blood Pressure
- _____ Cancer
- _____ Diabetes
- _____ Thyroid Disease

List All Medications Here

