Demetra Vagias MD, ND
2021 Midwest Rd.
Suite 200
Oak Brook, IL. 60523

HEALTH HISTORY SUMMARY

Date: _____

Name: _____ Age: _____ Birth date: _____ Blood Type_____

Address: _____ City: _____ State: ____ Zip_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Fax_____E- Mail_____

SSN: _____Married/ Single/ Divorced Male/ Female

Occupation: _____ Full or Part Time? Employer: _____

Nearest Relative: _____ Relationship: _____ Phone: _____

Who else can we reach?
In case of emergency? _____ Relationship: _____ Phone: _____

How did you hear about the Natural & Integrative Medicine? _____

Last physician or health practitioner seen? _____ When: _____

Date of last blood test? _____ What kind? _____

Your Current Health Problems
What is your main reason for coming in today? _____

_____

_____

How long has your main problem been troubling you?

_____

Describe the circumstances that led to your main health problem.

_____

List other health problems that are troubling you in order of importance: Length of time

1) _____

2) _____

3) _____

4) _____

Other problems: _____

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What kind of treatment have you received and from whom?
_____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health practitioner for your current problem? _____ For any other problem? _____

What was the therapy and what were the results?
_____

_____

Your Health History

The general state of your health is: excellent ___ good ___ avg. ___ fair ___ poor ___, and on the average your energy level from 1 to 10 (with 10 being the highest) is: _____

At what time of day is your energy the best? _____ Worst? _____

What is your current approximate weight? _____ Height? _____ Weight one year ago _____

As an adult what has been your maximum (excluding pregnancy) _____ and minimum weight _____

Please list the five most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? _____

1) _____ date _____

2) _____ date _____

3) _____ date _____

4) _____ date _____

5) _____ date _____

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist? _____
Have you in the past? _____ If so, when? _____

Are you currently working with a Doctor of conventional medicine? (M.D. or D.O.) _____

What childhood illnesses have you had?

___Measles	___Mumps	___Chickenpox	___Whooping Cough
___Polio	___Diphtheria	___Rheumatic Fever	___Scarlet Fever
___Smallpox	___Typhoid Fever	___Tuberculosis	___Mono - how long _____

Previous surgeries and hospitalizations (include dates)
_____
_____
_____

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Which of the following have you had? Indicate *now* or *past* as well as how often and date.

Now or Past		Year	Now or Past		Year	Now or Past		Year
_____	Pneumonia	_____	_____	Diabetes	_____	_____	Gonorrhea	_____
_____	Tonsillitis	_____	_____	Asthma	_____	_____	Venereal Disease	_____
_____	Chronic Ear Infections	_____	_____	Eczema	_____	_____	Syphilis	_____
_____	Chronic Infections	_____	_____	Heart Disease	_____	_____	Epilepsy	_____
_____	Canker Sores	_____	_____	Herpes	_____	_____	High Blood Pressure	_____
_____	Allergies	_____	_____	Hepatitis	_____	_____	Nucleosis	_____
_____	Thyroid Problems	_____	_____	Weight Problems	_____	_____	Anemia	_____

Do you have any allergies to any drugs, herbs, foods, animals or other? _____ If yes, please describe.

_____

Which of the following do you currently use?

	Amount (how often, how much and how long)		Amount (how often, how much and how long)
Alcohol	_____	Tobacco	_____
Hormones	_____	Coffee	_____
Cortisone	_____	Laxatives	_____
Sedatives	_____	Antacids	_____

Other Medications (please give full name, dosage and how long you have been taking the medication)

_____

_____

_____

Vitamins/Herbs _____

_____

Family History

Please list ages, health problems and cause of death if deceased

	Living (age)	Health Problems	Deceased (age)	Cause
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____

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	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Grandparents				
Maternal Grandmother	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____

What is your nationality? Please list all backgrounds and give approximate percentage
_____

You currently live with? Spouse ____ Partner ____ Parents ____ Friends ____ Children ____ Alone

Are you? Married _____ Separated _____ Divorced _____ Widowed ____ Single ____ In a Supportive Relationship

What is your current level of education? _____ Are you satisfied with this? _____

Do you have any children? _____ How many? _____ Ever had Toxemia during pregnancy? _____

Do your children have any health problems? _____

Do you have any blood relative (aunt, uncle, sibling, parent, grandparent) who has had any of the following?

___Allergies ___Arthritis ___Asthma ___Cancer ___Diabetes ___Anemia
___Depression ___Skin Disease ___Heart Attack ___Genetic Prob. ___High B.P. ___Stroke
___Ulcers ___Cataracts ___Thyroid Prob. ___Hypoglycemia ___Seizures ___SickleCells
___Venereal Disease

What is your weakest organ system and why? _____

Personal Habits

What do you enjoy most in your life? _____

What are your main interests or hobbies? _____

What do you worry about most in life? _____

Do you exercise? _____ If yes, what kind, how much and how often? _____

Do you have a religious or spiritual practice? _____ If yes, what? _____

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On a scale of 1 to 10 (with 10 being great), how would you rate the quality of your sleep? _____

Do you have problems falling or staying asleep? _____ How many hours do you sleep at night? _____

Do you wake up at night? _____ If yes, what time(s) do you usually wake up? _____

Do you ever sweat while sleeping? _____ How frequently and how much do you sweat? _____

Do you wake up feeling refreshed? _____ Do you ever nap or rest horizontally? _____How long? _____

What do you normally feel like temperature wise compared to others? *Warmer Cooler Average*

What are the temperatures of your hand and feet generally? *Warm Cool Average*

Do you enjoy your work? _____ Do you take vacations? _____

Are you currently in a happy, satisfying relationship with someone? *Very Much Mostly Somewhat Not*

How often do you suffer from colds, the flu, sore throat, yeast infections throughout the year?

_____

When you rise quickly from a sitting or lying position, do you ever get dizzy? _____ How often?_____

_____

Female Reproduction

Age of first menses _____ If periods have stopped, at what age did they stop?_____

Are your cycles regular? _____ Period begins every _____ days. How long are your periods? _____

Are your periods heavy *medium light* and what color is the blood light *red dark red medium clots*

Do you have any spotting or bleeding between periods? _____ Any cramps with period? _____

Do you have any premenstrual symptoms? *Water Retention Breast Tenderness Irritability Depression*

Headaches Mood Swings Food Cravings

Other _____

Number of pregnancies _____ Number of abortions _____ Number of live births _____

Number of miscarriages _____ Any problems getting pregnant? _____

Do you get yearly PAP smears? _____ Any abnormal PAPs? _____ Any breast lumps? _____

Are you currently sexually active? _____ How often? _____ Is this more or less than last year? _____

Do you use birth control? _____ What type of birth control do you currently use? _____

Have you ever been physically or sexually abused? _____ How old and how often? _____

Male Reproduction

How often do you have to get up at night to urinate? _____ Has this increased in recent years? _____

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Any problems with impotency (getting or maintaining an erection)? _____ Any sores on penis? _____

Do you have any abnormal discharge from the penis? _____ Any venereal diseases? _____

Any prostate problems? _____ Ever have your prostate examined, if so, when? _____

Are you currently sexually active? _____ How often? _____ Is this more or less than last year? _____

Do you use birth control? _____ What type of birth control do you currently use? _____

Have you ever been physically or sexually abused? _____ How old and how often? _____

Digestion

Do you have any problems with gas, bloating or fullness after eating? _____ How often? _____

How severe? _____ Do you have gas in *upper abdomen lower abdomen both areas?*

How long have you had this problem? _____ How often do you have bowel movements? _____

Do you ever have any *blood mucus undigested food black* stools? Any rectal itching? _____

Do your stools tend to be *formed* or *loose*? How often do you have diarrhea? _____

Do you ever have alternating constipation and diarrhea? _____ How often do you have thin, long and narrow

stools? _____ How often do you have small and hard stools? _____

Do you ever have yellow or light colored stools, if so how often? _____

How often do your stools have a strong disagreeable odor? _____

Have you ever fasted? _____ Juice or Water? _____ For how long have you fasted? _____

How did you feel while you were fasting? _____

Have you traveled outside the US in last five years? _____ Have you been camping in last five years?_____

Kidneys and Bladder

Have you had recurrent bladder infections? _____ How were they treated? _____

How many bladder infections have you had in the last three years? _____

Have you ever had any burning sensation during or after urination? _____

Is your urine *dark yellow bright yellow cloudy pale clear*? Does your urine have a strong odor? _____

Do you have difficulty starting or stopping urination? _____ Do you have difficulty perspiring? _____

Do you perspire when you exercise? *Lightly Moderately Heavily* Do you perspire when not exercising?
If so, at what times? _____ Does your perspiration have a strong odor? _____

Does your body temperature tend to run lower *higher or average* compared to others? _____

Occupational/Household

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How long have you lived at your present address? _____ Where have you lived previously?_____

Please describe location, if old or new construction, damp or moldy conditions, etc.

_____

Do you have specialized air filtration at home? _____ Do you live in the city? _____

Do you work in an office building? _____ Do the windows open? _____

Do you have specialized air filtration at your work place? _____

Do you work in the presence of toxic fumes or chemicals? _____

Do any of your hobbies involve toxic materials? _____

Are you currently exposed to second hand smoke? _____ Do you use *bottled* *filtered* or *tap* water?

Is there anything else you would like to comment on?

_____

_____