WESTERN WISCONSIN HEALTH

Personal Health History & Self Reflection Inventory

Name:_____ **Date:** _____

WWH Medical Record #: _____ **Date of Birth**_____ **Age** _____

What is the best contact phone #_____May we leave a message at this number? ☐ Yes ☐ No

**Please note all nonverbal communication will be done via MyChart, which is part of the Western Wisconsin Health Electronic Medical Record System. Please sign up at https://www.wwhealth.org/mychart/

Preferred Pharmacy (Name, location, phone #):_____

Primary Care Provider (if not joining our Primary Care practice)? _____

What health issues do you want to focus on during this visit?

Pharmaceuticals and Supplements:

Do you have Medication allergies? ☐ Yes ☐ No If yes, please list:

Medication	Reaction	Medication	Reaction

Please list all prescribed and over-the-counter medications you take regularly. ***Please include all supplements, vitamins or herbal products.***

Medicine/ Supplement including Dose	Frequency	Dose	Frequency
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

Past Medical History: List any major past illnesses, hospitalizations (include year or date if known).

	Date		Date

Past Surgical History: List any past surgeries (and what year/date).

	Date		Date

Family History: Have your close relatives (parent, brother or sister, child, grandparent) had the following?

	Yes	No	If yes, which relative	Age at Diagnosis
Heart attack, angina				
Stroke				
High blood pressure				
High Cholesterol				
Diabetes				
Thyroid disease				
Breast cancer				
Other Cancer--what type?				
Kidney Disease				
Osteoporosis				
Rheumatoid Arthritis				
Asthma				
Mental Health disorder				
Substance Abuse				

Please outline your use of the following, past or present:

Product:	Current Use? Yes/No	Quantity Per Day	Quantity Per Week	Past Use? Yes/No	Do others have concern about your usage?
Tobacco					
Alcohol					
Recreational Drugs					
Caffeine:					

Are you sexually active? ❑ Yes ❑ No are you happy with your sexual life? _____

Personal and Professional Development:

Current or past occupation: _____

❑ Retired? ❑ Working at home? ❑ Care-taking? ❑ Disabled? ❑Unemployed?

How many hours do you work per week? _____

What is your typical schedule like? _____

_____

Are you happy with your occupation? _ Yes No

Why? _____

Relationships:

Relationship status: _____ if married or partnered, what is your relationship length? _____

With whom do you live (spouse/significant other, children, parents, roommates, pets)?

_____

_____

Name (optional): _____ Age: _____ Relationship: _____
Name (optional): _____ Age: _____ Relationship: _____
Name (optional): _____ Age: _____ Relationship: _____
Name (optional): _____ Age: _____ Relationship: _____
Name (optional): _____ Age: _____ Relationship: _____
Name (optional): _____ Age: _____ Relationship: _____

_____

Social Connections:

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?

❑ Never ❑ Once a week ❑ Twice a week ❑ Three times a week ❑More than three times a week

How often do you get together with friends or relatives?

❑ Never ❑ Once a week ❑ Twice a week ❑ Three times a week ❑More than three times a week

How often do you attend church or religious services?

❑ Never ❑ 1 to 4 times per year ❑ More than 4 times per year

Do you belong to clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?

❑ Yes ❑ No

How often do you attend meetings of the clubs or organizations you belong to?

❑ Never ❑ 1 to 4 times per year ❑ More than 4 times per year

What is your current marital status?

❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑ Never married ❑ Living with a partner

Intimate Partner Violence:

Within the past year, have you ever been afraid of your partner or ex-partner?
❑ Yes ❑ No

Within the past year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?
❑ Yes ❑ No

Within the past year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?
❑ Yes ❑ No

Within the past year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?
❑ Yes ❑ No

Past Gyn/Obstetrical History: List any past pregnancies.

Vaginal Births		Miscarriage/ Still births	
Caesarian Sections		Pregnancy Terminations	
Abnormal PAP tests		Other GYN Procedures	

Movement, Exercise and Rest:

Please describe your usual physical activity. What forms of exercise and movement do you enjoy?

Activity	**EZ to Moderate Effort: Minutes / Week**	**Working up a Sweat: Minutes / Week**
Cardio and / or Walking		
Balance / Core / Aquatic		
Weights or Resistance		
Other:		

Mind-Body Connection:

Rate the amount of stress in your life: □ None □ A Little Bit □ Moderate □ Quite a Lot □ Extreme
How well do you manage stress? □ Not at All □ A Little Bit □ Moderate □ Quite well □ Excellent
What are the main sources of stress in life? (Personal, professional, financial etc.) _____

METHODS OF COPING WITH STRESS	**# of Times / Week**
7+ hours of sleep	
15+ minutes spent outdoors	
No screens 3 hours before bed	
Mindful breathing or meditation	
Feeling rested & positive in the morning	
Other de-stressing activity:	

Nutrition: Please list any food allergies or sensitivities:

Are you currently on a special diet? If so, please describe: _____

How many servings of fruit do you usually eat/drink each day? _____
(Serving = 1 small piece of fruit, ½ cup fruit juice, ½ cup canned or chopped fruit, ¼ cup dried fruit)

How many servings of vegetables do you consume each day? _____
(Serving = ½ cup raw or cooked vegetables, 1 cup fresh, green leafy vegetables, ¼ cup dried vegetables or 1 small piece)

How much water do you drink on a typical day? _____
Example: Four 16-ounce bottles water/day

Soda (diet or regular) _____ # Other sugary drinks or 100% fruit juice: _____
Cups of coffee per day _____ # cups of tea per day _____

Please indicate the number of times or servings you consume during an average week:

How often do you eat the following per week: # servings or # times *(1 serving meat = 3 ounces cooked meat, poultry or fish = a deck of cards sized piece)*
Red meat (beef, pork, lamb, veal, etc.) _____
Fish/seafood _____
Poultry (chicken, turkey, duck, quail, etc.) _____
Eggs _____
Animal-sourced dairy (cow/sheep/goat/etc.) milk, yogurt, kefir, cheese, cottage cheese, etc. _____
Soy (tofu, tempeh, edamame) _____
Beans/legumes - including peanuts _____
Nuts, seeds or nut butters _____
Protein powder or bars _____
Chips or crackers _____
Desserts and other sweets _____

How often do you eat out at restaurants or fast food places per week? _____
Which restaurants do you typically visit? _____

How many hours of sleep do you usually get each night? _____
Describe any issues you have with sleep._____
_____

Physical Environment:
Do you have specific health concerns about your current home or environment (Quality of air, water, etc.)?
_____
Have you had hazardous environmental or occupational exposures? If yes, please describe.
_____

Trauma History: Have you ever been the victim of trauma or abuse (including sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or a natural disaster)? ☐ Yes ☐ No
If yes, is this an active issue in your life that you would like to address while you are here? ☐ Yes ☐ No
_____
_____

Do you have a Racial/Culture heritage that is important to you? _____

_____

Please list all physicians that you see. (Please include Mental Health Professionals)

Name	Address	Specialty, or condition that is being treated

Please list any complementary and/or alternative practitioners you see or have seen in the past (i.e., chiropractor, acupuncturist, naturopath, massage therapist, spiritual healer, etc.).

Approximate Date(s) of Treatment	Name of Therapist or Treatment Facility	Type of Treatment (e.g. Reiki, Qi Gong, Sand Tray)	Reason for Treatment	Beneficial Experience?

What are your health goals? What are your overall goals for improving your health and your life? ___

_____

_____

_____

_____

Is there anything else that would be helpful for us to know about you? _____

_____

_____

Review of Symptoms: Please check no or yes for the following **current** symptoms (**within past 3 months**)

GENERAL	Yes	No		GASTROINTESTINAL	Yes	No
Fever				Diarrhea/Constipation		
Sweats at night				Indigestion/heartburn		
Hot flashes				Nausea		
Temperature intolerance				Blood in stool		
Excessive thirst				**GENITOURINARY**		
Fatigue				Pain or burning on urination		
Sleep difficulties				Frequent urination		
Daytime sleepiness				Waking to urinate more than once at night		
Unplanned weight change				Excessive urination		
SKIN				Difficulty emptying bladder		
Rash				Urinary incontinence		
New or changing moles				Decreased sexual desire		
EYES				Pain with intercourse		
Pain				Sexually Transmitted Diseases		
Redness				Fertility issues		
Vision change				**Men:**		
EAR, NOSE, THROAT				Erectile dysfunction		
Hearing loss				**Women:**		
Ringing in ears				Heavy vaginal discharge		
Dizziness or vertigo				Heavy menstrual bleeding		
Bleeding gums				Painful menstrual periods		
Nosebleeds				Irregular menstrual bleeding		
BREAST				**MUSCULOSKELETAL**		
Breast Pain				Generalized or all-over pain		
Masses and or Lumps				Joint pain		
Nipple discharge				Stiffness		
Skin changes				Joint swelling		
CARDIOVASCULAR				Joint redness		
Chest pain				Back or neck pain		
Heart murmur				**NEUROLOGICAL**		
Irregular heart beat (palpitations)				Abnormal gait (Trouble Walking) or falls		
Leg swelling or edema				Headache severe and/or frequent		
PULMONARY				Seizures		
Wheezing or shortness of breath				Muscle weakness, TIA or stroke		
Chronic cough				Fainting or loss of consciousness		
HEMATOPOIETIC				Localized numbness, tingling, neuropathy		
Swollen lymph glands				**PSYCHOLOGICAL**		
Blood clots				Anxiety		
Excessive bleeding				Depression		
Anemia				Memory loss		
				Mood swings		