Strega Gardens

Strega Gardens & Herbal Care
Health History Form

Name:_____
Date:_____

Address:_____

_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____

City:_____ State:_____ Zip Code:_____

Sex: _____ Date of Birth:_____ Height:_____ Weight:_____

Occupation:_____

Reason for Today's visit:_____

_____

_____

How long has this been going on?_____

When did it start? _____

_____

How would you rate your overall health today on a scale of 1-10 (1=poor, 10= excellent):
_____

If referred who referred you?_____

What medications are you currently taking? Please include prescriptions, over the counter drugs, herbs, vitamins and supplements.

_____

_____

Do you have any allergies? Seasonal?_____

What?_____

Medications?__ What?_____

_____

List any present or prior surgeries, serious injuries, or illnesses you have had and include the dates:_____

_____

_____

List any health care practitioners who you are currently consulting. List last dates seen and phone numbers if available.

_____

_____

_____

When was your last physician visit?_____

When was your last gynecological exam?_____

Do you have any gynecological complaints? If so what?_____

_____

Do you have any diagnosed medical conditions?_____

Do you exercise?_____

What kind of exercise?_____

_____

How often?_____

Please check if you or anyone in your family have had any problems with any of the following:

__Allergy
__Area of inflammation Where_____
Type_____
__Artritis Where_____
__Asthma
__High Blood Pressure ___/___
__Low Blood Pressure ___/___
__Bruise Easily
__Bursitis Where_____
__Cancer or Tumor Where_____
__Chest Pain
__Diabetes
__Mental Illness
__Turberculosis
__Emphysemia
__Heart Condition
__Infectious Condition
__Numbness/Tingling Where_____
__Osteoporosis
__Sciatica
__Scizures/Convulsions
__Shortness of Breath
__Skin Condition/Rash Where_____
__Stroke
__Varicose Veins Where_____
__Glacucoma
__Problems with Thyroid

How much do you smoke?	per day__	per week__
How much do you drink?	per day__	per week__
How much coffee do you drink?	per day__	per week__
Soft drinks?	per day__	per week__
How much sleep do you get at night ?	hours___	
Is your sleep restless or disturbed?	_____	

Are you experiencing any of the following?

__Pain
__Fever
__Volmitting
__Blood in Stool
__Diarrhea
__Black Tarry Stool
__Frequent Urination
__Night Sweats

__Depression with Thoughts of Suicide
__Recent fainting or Loss of Consciousness
__Bleeding of any Kind
__Visual Disturbances, Visual loss
__Unusual Shortness of Breath
__Lumps,Swellings, or Sore Lymph Nodes
__Persistent or Severe Fatigue
__Erectile Dysfunction

I hereby give my consent for the recommendations by the alternative practitioner and herbalist Laura Clemmons. I understand that she is not taking the place of a medical doctor but works in a complementary way to health care services provided by healthcare practitioners licensed by the state you are currently living in.

Signature_____

Date_____