Sedona Wellness Retreat
125 Kallof Place Sedona, Arizona 86336
(928) 239-4589 • fax 928-224-7000
info@sedonawellnessretreat.com

Medical and Health History

Name: _____Gender:_____Current Date:_____

Birth Date:_____Age:____City lived in the most until 18_____Height _____

Weight ____Weight that you feel your best ____ Greatest adult weight___ Lowest adult weight _____

Please choose one: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed/Widower

Address:_____

City:_____State:_____Zip Code:_____Country:_____

Best Contact Phone:_____ 2nd Best Phone # _____

Email Address:_____

Occupation (previous if retired):_____

Employer:_____ City: _____Work Phone:_____

Emergency Contact:_____Relationship: _____Phone:_____

Please indicate the diagnosis/condition and/or reason for wanting to attend Sedona Wellness Retreat:

_____

_____

_____

_____

_____

Last medical exam (clinic name/date): _____

Most recent blood work (clinic name/date): _____

Most recent other tests (clinic name/date): _____

Present State of Health: Please indicate which percentage best describes your current situation:

- ☐ 100% Normal; no complaints no evidence of disease.
- ☐ 90% Able to carry on normal activity; minor signs and/or symptoms of disease.
- ☐ 80% Normal activity with effort; some sign and/or symptoms of disease.
- ☐ 70% Cares for self. Unable to carry on normal activity or do active work.
- ☐ 60% Requires considerable assistance but is able to care for most of oneself.
- ☐ 50% Requires considerable assistance and frequent medical care
- ☐ 40% Disabled; requires special care and assistance
- ☐ 30% Severely disabled; hospitalization is indicated
- ☐ 20% Very sick; hospitalization necessary; active supportive treatment needed.
- ☐ 10% Fatal processes progressing rapidly.

Please note: We are not a 24 hour medical facility. Deliberately misrepresenting your current state of health may be grounds for immediate dismissal from our program without refund.

Medical History Related to Cancer Diagnosis

(please go to page 3 if not applicable)

Date of initial diagnosis:_____Primary Site: _____Type of cancer: _____
Stage:_____Grade:_____Tumor Markers:_____

Were any of the following used in diagnosis? (Attach copy of reports)

☐ MRI ☐ CAT scan ☐ Ultrasound ☐ PET scan ☐ X-Rays ☐ Other:_____

Was there a recurrence after initial treatment? ☐No ☐Yes. If so, please describe: _____
_____
_____

Describe current treatments and current status: _____
_____
_____

Metastasis ☐ Yes ☐ No. Describe any metastasis at initial diagnosis or currently: _____
_____
_____

If Breast Cancer:

☐ER+ ☐ER- ☐PR+ ☐PR- ☐HER2/neu+ ☐HER2/neu- ☐BRAC I ☐BRAC II

Timeline of Treatments (from diagnosis until now)

Date/s of Treatment	Choose one	Details
	☐Surgery ☐Chemo ☐Radiation ☐Other	
	☐Surgery ☐Chemo ☐Radiation ☐Other	
	☐Surgery ☐Chemo ☐Radiation ☐Other	
	☐Surgery ☐Chemo ☐Radiation ☐Other	
	☐Surgery ☐Chemo ☐Radiation ☐Other	
	☐Surgery ☐Chemo ☐Radiation ☐Other	
	☐Surgery ☐Chemo ☐Radiation ☐Other	

Family Health History

Do you have a family history of any of the following conditions? Please mark all that apply:

☐ Cancer	☐ Diabetes	☐ Heart Disease	☐ High Blood Pressure
☐ Epilepsy	☐ Physical Abuse	☐ Emotional Abuse	☐ Hay-fever
☐ Asthma	☐ Mental Illness	☐ Tuberculosis	☐ Stroke
☐ Glaucoma	☐ Hives	☐ Kidney Disease	☐ Parkinson's disease
☐ Alzheimer's	☐ Depression	☐ Anxiety	☐ Others:_____

Relationship	**Age** (or age at death)	**Medical or Health History**	**Current Health Scale** (rate vitality on a 1-10 -- where 0 is deceased & 10 is athletic)
Mother			
Mother's Mother			
Mother's Father			
Father			
Father's Father			
Father's Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Children			
Children			
Children			
Spouse/Partner			

Personal Health History

My health as a child was: ☐Good ☐Fair ☐Poor

Childhood illnesses: ☐Scarlet Fever ☐German Measles ☐Measles ☐Pertussis ☐Mumps ☐Rheumatic Fever ☐Chicken Pox ☐Diphtheria

Other illnesses (past or present):

☐Tuberculosis	☐Typhoid	☐Osteoarthritis	☐Rheumatoid Arthritis
☐Pneumonia	☐Asthma/Hay fever	☐Tonsillitis	☐Heart Disease
☐Epilepsy	☐Diabetes	☐Alcoholism	☐Hypertension
☐Mononucleosis	☐Kidney disease	☐Stroke	☐Glaucoma
☐Thyroid disorder	☐Infertility	☐Lyme disease	
☐Depression	☐Sleep Apnea	☐Others: _____	

How would you describe your current sense of well-being? _____

What is your stamina or general energy level like? _____

Do you sleep well? ☐ Yes ☐ No Average hours sleep per night_____

Do you wake rested? ☐ Yes ☐ No How to you feel after waking?_____

Do you exercise regularly? ☐ Yes ☐ No Type?_____How often? _____

Are you willing to make dietary and lifestyle changes to improve your health? _____

Do you take Aspirin? ☐Y ☐N ☐Hx (History of)

Pills per week? _____ Milligrams per pill? _____ Stomach Upset? ☐Y ☐N

Other pain reliever? ☐Y ☐N ☐Hx

Type? _____ Milligrams per pill? _____ Pills per day? _____

Caffeine? ☐Y ☐N ☐Hx

Soda _____ Tea _____ Coffee _____ Chocolate _____Other_____

Tobacco? ☐Y ☐N ☐Hx Do you smoke/chew?_____

Packs per day _____ Previous, but quit. When? _____

Alcohol? Never ____ Rarely___ Moderate_____ Daily_____ When did you quit? _____

Recreational Drugs? Never ____ Rarely___ Past ____ Recently ____ When did you quit? _____

Prescription Medications: (Attach sheet if more space needed)

Name	Dosage (often in mg)	When and how many daily	Reason for Taking	How long have you been taking it?

Dietary Supplements (Attach sheet if more space needed)

Name	Dosage (often in mg)	When and how many daily	Reason for Taking	How long have you been taking it?

Allergies

				Symptoms experienced
Penicillin or antibiotics	☐Y	☐N	☐Hx	_____
Stinging insects	☐Y	☐N	☐Hx	_____
Aspirin	☐Y	☐N	☐Hx	_____
Morphine or Demerol	☐Y	☐N	☐Hx	_____
Novocain or anesthetics	☐Y	☐N	☐Hx	_____
Antitoxins (i.e. - Tetanus)	☐Y	☐N	☐Hx	_____

List other known allergies (drugs/chemicals/food, etc):

_____

_____

_____

Food Issues/Sensitivities

Do you have any food allergies/intolerances/sensitivities? ☐ Yes ☐No

If yes, please list: _____

_____

Do any foods give you significant gas, pain, or bloating? ☐ Yes ☐No

If yes, please list:_____

_____

Typical Diet Please list the foods you eat most often for each meal:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Special diet/restrictions _____

Vaccinations (type; year; please note any adverse reactions):

_____

_____

Environmental Exposures Have you had an occupational or environmental exposure to noxious or hazardous substances? ☐No ☐Yes Explain: _____

_____

_____

Have you ever been exposed to any of the following?

- Agricultural chemicals (pesticides, insecticides)? ☐ No ☐ Yes
- Industrial/workplace chemicals? ☐ No ☐ Yes How much? _____ How long? _____
- Second hand smoke? ☐ No ☐ Yes How much? _____ How long? _____
- Electromagnetic fields? ☐ No ☐ Yes How much? _____ How long? _____
- Other? _____ ☐ No ☐ Yes Explain _____

All non-cancer related events: Please list all that apply

Surgeries, Hospitalizations, Major Injuries, Serious Illness	**When?**	**Please explain your diagnosis and/or treatment**

Medical Devices: Anything inside the body that you DID NOT come into this world with. Examples include: ports, stents, pacemaker; silicone or saline implants; pins, screws, or plates; IUD; Hearing aids; knee or other joint replacements; eye surgeries (cataracts); etc. ☐ Yes ☐ No

If yes, please list: _____

_____

Please Indicate as Appropriate – either Yes, No, or in the Past (Hx or history of)

Eyes

Wear vision correction	☐ Y	☐ N	☐ Hx	Eye disease	☐ Y	☐ N	☐ Hx
Blurred vision	☐ Y	☐ N	☐ Hx	Eye injury	☐ Y	☐ N	☐ Hx
Double vision	☐ Y	☐ N	☐ Hx	Halos	☐ Y	☐ N	☐ Hx
Glaucoma	☐ Y	☐ N	☐ Hx	Sparks	☐ Y	☐ N	☐ Hx

Ear/Nose/Throat/Mouth

Hearing loss	☐ Y	☐ N	☐ Hx	Earaches	☐ Y	☐ N	☐ Hx
Ringing in ears	☐ Y	☐ N	☐ Hx	Drainage	☐ Y	☐ N	☐ Hx
Sinus pain	☐ Y	☐ N	☐ Hx	Nose bleeds	☐ Y	☐ N	☐ Hx
Runny nose	☐ Y	☐ N	☐ Hx	Mouth sores	☐ Y	☐ N	☐ Hx
Bleeding gums	☐ Y	☐ N	☐ Hx	Swollen glands	☐ Y	☐ N	☐ Hx
Bad Breath	☐ Y	☐ N	☐ Hx	Dental Problems	☐ Y	☐ N	☐ Hx
Sore throat/voice change	☐ Y	☐ N	☐ Hx				

Eye/ Dental History

Last eye exam_____ Current concerns: _____

Last dental cleaning _____ Current concerns: _____

Silver/Mercury Amalgams ☐Never ☐Current How many? _____ ☐Removed When removed? _____

Root Canals ☐No ☐Yes How many?_____ When first? _____When last?_____

Dentures/Partials ☐No ☐Top ☐Bottom When first? _____When last? _____

Implants ☐No ☐Yes How many? _____ When first? _____When last? _____

Reconstructions ☐No ☐Yes How many? _____ When first? _____When last? _____

Cardiovascular & Lungs

Stroke	☐Y	☐N	☐Hx	Blood pressure (BP)	_____/_____		
Heart trouble	☐Y	☐N	☐Hx	Last chest x-ray	Date: _____		
Palpitations (flutters)	☐Y	☐N	☐Hx	Pneumonia	☐Y	☐N	☐Hx
Wheezing	☐Y	☐N	☐Hx	Chest pain	☐Y	☐N	☐Hx
Frequent cough	☐Y	☐N	☐Hx	Cough with blood	☐Y	☐N	☐Hx
Bronchitis	☐Y	☐N	☐Hx	Mitral Valve Prolapse	☐Y	☐N	☐Hx
Rheumatic Fever	☐Y	☐N	☐Hx	Asthma	☐Y	☐N	☐Hx

Shortness of breath ☐Y ☐N ☐Hx /☐Walking or ☐Laying Down?

Swelling of extremities ☐Y ☐N ☐Hx /☐Feet &/or ☐Ankles &/or ☐Hands?

Blood & Lymphatic

Cuts are slow to heal	☐Y	☐N	☐Hx	Anemia, Type_____	☐Y	☐N	☐Hx
Tendency Bleeding/bruise	☐Y	☐N	☐Hx	Phlebitis or Blood clots	☐Y	☐N	☐Hx
Varicose veins	☐Y	☐N	☐Hx	Past transfusion	☐Y	☐N	☐Hx
Enlarged glands	☐Y	☐N	☐Hx	Date received:_____ Amount _____			

Skin

Rash or itching	☐Y	☐N	☐Hx	Change in skin color	☐Y	☐N	☐Hx
Itching	☐Y	☐N	☐Hx	Change in nails	☐Y	☐N	☐Hx
Dry skin	☐Y	☐N	☐Hx	Change in hair	☐Y	☐N	☐Hx
Concern/change in mole	☐Y	☐N	☐Hx				

Musculoskeletal

Joint pain	☐Y	☐N	☐Hx	Joint stiffness	☐Y	☐N	☐Hx
Weakness of muscle	☐Y	☐N	☐Hx	Joint swelling	☐Y	☐N	☐Hx
Weakness of joint	☐Y	☐N	☐Hx	Muscle pain or cramps	☐Y	☐N	☐Hx
Back pain	☐Y	☐N	☐Hx	Cold extremities	☐Y	☐N	☐Hx
Difficulty in walking	☐Y	☐N	☐Hx	Varicose veins	☐Y	☐N	☐Hx
Hernia	☐Y	☐N	☐Hx				

Gastrointestinal

Abdominal pain	☐Y	☐N	☐Hx	Acid Indigestion	☐Y	☐N	☐Hx
Acid Reflux	☐Y	☐N	☐Hx	Blood in stool	☐Y	☐N	☐Hx
Change in bowel movement	☐Y	☐N	☐Hx	Colitis	☐Y	☐N	☐Hx
Constipation	☐Y	☐N	☐Hx	Diarrhea	☐Y	☐N	☐Hx
Diverticulitis	☐Y	☐N	☐Hx	Helicobacter Pylori	☐Y	☐N	☐Hx
Hemorrhoids	☐Y	☐N	☐Hx	Hiatal Hernia	☐Y	☐N	☐Hx
Irritable Bowel Syndrome	☐Y	☐N	☐Hx	Liver/ Gallbladder disease	☐Y	☐N	☐Hx
Loss of appetite	☐Y	☐N	☐Hx	Nausea or vomiting	☐Y	☐N	☐Hx
Ulcers	☐Y	☐N	☐Hx	Night sweats	☐Y	☐N	☐Hx
Change in appetite	☐Y	☐N	☐Hx	Unexplained fatigue	☐Y	☐N	☐Hx

Unexplained fever/chills	☐Y	☐N	☐Hx	Change in sleep habits	☐Y	☐N	☐Hx	
Unexplained weakness	☐Y	☐N	☐Hx	Recent change in weight	☐Y	☐N		

Does food generally sit well in your stomach and digest without difficulty? ☐Yes ☐No
Do you have gas or abdominal bloating? ☐Yes ☐No
Do you need to strain to have a bowel movement? ☐Yes ☐No
How often do you have a bowel movement? (Please circle one) _____x Daily -or-_____x Weekly
Are your bowel movements generally formed or loose?_____Color?_____
Do you have hemorrhoids or any other rectal or bowel problems? ☐Yes ☐No
If yes explain:

_____

_____

Parasites ☐Y ☐N ☐Hx

When diagnosed? _____Where diagnosed? _____

How diagnosed?_____
How treated? _____

Genitourinary

Frequent urination	☐Y	☐N	☐Hx	Burn/painful urination	☐Y	☐N	☐Hx	
Blood in urine	☐Y	☐N	☐Hx	Change in force/stream	☐Y	☐N	☐Hx	
Incontinence	☐Y	☐N	☐Hx	Kidney stones	☐Y	☐N	☐Hx	
Urinary tract Infections	☐Y	☐N	☐Hx	Male - testicle pain	☐Y	☐N	☐Hx	
Sexually active	☐Y	☐N	☐Hx	Sexual difficulty	☐Y	☐N	☐Hx	
STDs	☐Y	☐N	☐Hx	Birth control method? _____				

Do you have a history of the following concerns?

☐Yeast ☐Gonorrhea ☐Syphilis ☐Herpes ☐Chlamydia ☐Other_____

Immune

Catch every cold/flu?	☐Y	☐N	☐Hx	Cancer?	☐Y	☐N	☐Hx	
Difficulty clearing cold?	☐Y	☐N	☐Hx	Type: _____				
Herpes Simplex Virus	☐Y	☐N	☐Hx	Chicken Pox Virus	☐Y	☐N	☐Hx	
HIV	☐Y	☐N	☐Hx					

Other Infectious Diseases: _____ _____ Hepatitis ☐A ☐B ☐C ☐None

Endocrine

Glandular issues	☐Y	☐N	☐Hx	Heat intolerance	☐Y	☐N	☐Hx	
Excessive thirst	☐Y	☐N	☐Hx	Cold intolerance	☐Y	☐N	☐Hx	
Excessive urination	☐Y	☐N	☐Hx	Recent weight change	☐Y	☐N	☐Hx	
Change in hat/glove size	☐Y	☐N	☐Hx	Skin becoming drier	☐Y	☐N	☐Hx	
Hair loss	☐Y	☐N	☐Hx	Diabetes	☐Y	☐N	☐Hx	
Thyroid Disease	☐Y	☐N	☐Hx					

Neurological Mental and Emotional Health

Lightheaded/dizzy	☐Y	☐N	☐Hx	Tremors(shaking)	☐Y	☐N	☐Hx	

Freq. /recurring headaches	☐Y	☐N	☐Hx	Numbness or tingling	☐Y	☐N	☐Hx
Head injury	☐Y	☐N	☐Hx	Convulsion/Seizure	☐Y	☐N	☐Hx
Paralysis	☐Y	☐N	☐Hx	Memory loss	☐Y	☐N	☐Hx
Nervousness/anxiety	☐Y	☐N	☐Hx	Depression	☐Y	☐N	☐Hx
Insomnia	☐Y	☐N	☐Hx	Bipolar/psychotic episodes	☐Y	☐N	☐Hx

Mental and Emotional Health: please provide details on the line below each question.

Have you ever experienced a significant loss in your life? ☐Y ☐N

_____

Have you ever been abused mentally, emotionally, verbally, sexually, and/or physically? ☐Y ☐N

_____

Have you ever or are you currently being treated for a mental or emotional concern? ☐Y ☐N

_____

Have you ever received inpatient treatment for mental or emotional concerns? ☐Y ☐N

_____

Have you ever purposely tried to harm yourself? ☐Y ☐N

_____

Female Gynecological History

Do you experience:

Excessive cramping	☐Y	☐N	☐Hx	Heavy flow	☐Y	☐N	☐Hx
Spotting between periods	☐Y	☐N	☐Hx	Symptoms of PMS	☐Y	☐N	☐Hx
Abnormal discharge	☐Y	☐N	☐Hx	Are your cycles regular	☐Y	☐N	☐Hx
Endometriosis	☐Y	☐N	☐Hx	Ovarian cysts	☐Y	☐N	☐Hx
Uterine fibroids	☐Y	☐N	☐Hx	Pain on intercourse	☐Y	☐N	☐Hx
Sexually active	☐Y	☐N	☐Hx	Sexual difficulties	☐Y	☐N	☐Hx
Difficulty conceiving	☐Y	☐N	☐Hx	Explain: _____			

Breasts

I do self-exams regularly	☐Y	☐N	☐Hx	Breast changes or lumps	☐Y	☐N	☐Hx
Any pain or tenderness	☐Y	☐N	☐Hx	Breast/Nipple discharge	☐Y	☐N	☐Hx
Do you have implants	☐Y	☐N	☐Hx				

Mammogram ☐Y ☐N ☐Hx When? _____ Results: ☐ Normal ☐ Abnormal

Date of last PAP:_____ ☐Normal ☐Abnormal If abnormal in past, when? _____

Age menses began_____Number of flow days_____

Cycle length_____Date of last menstrual period_____

Number of: Pregnancies:_____Live Births:_____Miscarriages:_____Abortions:_____

Type of birth control used: _____

Menopausal symptoms (list): _____

Anything else you would like to add:

_____

_____

_____