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

Medical and Health History

Name: _____ 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 (before Retirement): _____
Employer: _____ City _____ Work Phone: _____
Emergency Contact: _____ Relationship _____ Phone: _____

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

_____
_____
_____
_____

Last Medical Exam (Where/Date): _____

Most Recent Blood work (Where/Date): _____

Most Recent Other Tests (Where/Date): _____

Present State Of Health: Please indicate which category and letter your present health is in:

1. Able to carry on normal activity to work. No special care is needed.
   - A. ☐ 100% Normal; no complaints no evidence of disease.
   - B. ☐ 90% Able to carry on normal activity; minor signs and/or symptoms of disease.
   - C. ☐ 80% Normal activity with effort; some sign and/or symptoms of disease.

2. Unable to work. Able to live at home, and care for most personal needs. A varying amount of assistance needed.
   - A. ☐ 70% Cares for self. Unable to carry on normal activity or do active work.
   - B. ☐ 60% Requires considerable assistance, but is able to care for most of oneself.
   - C. ☐ 50% Requires considerable assistance and frequent medical care

3. Unable to care for self. Requires equivalent of institutional or hospital care. Disease may be progressing rapidly.
   - A. ☐ 40% Disabled; requires special care and assistance
   - B. ☐ 30% Severely disabled; hospitalization is indicated
   - C. ☐ 20% Very sick; hospitalization necessary; active supportive treatment needed.
   - D. ☐ 10% Moribund; fatal processes progressing rapidly.

Medical History Related to Cancer Diagnosis

(please go to page 3 if not appropriate)

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	
	☐ Surgery ☐ Chemo ☐ Radiation ☐ Other	

Family Health History

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** (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

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? _____

Aspirin? ☐ Yes, currently ☐ Yes, in past ☐ No

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

Other pain reliever? ☐ Yes, currently ☐ Yes, in past ☐ No

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

Caffeine? ☐ Yes, currently ☐ Yes, in past ☐ No

Soda _____ Tea _____ Coffee _____ Chocolate _____ Other_____

Tobacco? Do you smoke/chew? ☐ Yes, currently ☐ Yes, in past ☐ No

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

Dietary Supplements (Attach sheet if more space needed)

Name	Dosage (often in mg)	When and how many daily	Reason for Taking

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

Eyes

Wear glasses/contacts	☐Y	☐N	☐ Hx	Eye disease or injury	☐Y	☐N	☐ Hx
Blurred or double vision	☐Y	☐N	☐Hx	Halos or Sparks	☐Y	☐N	☐Hx
Glaucoma	☐Y	☐N	☐Hx				

Ear/Nose/Throat/Mouth Hearing

Loss or ringing	☐Y	☐N	☐Hx	Earaches or drainage	☐Y	☐N	☐Hx
Sinus pain or Runny nose	☐Y	☐N	☐Hx	Nose bleeds	☐Y	☐N	☐Hx
Mouth sores	☐Y	☐N	☐Hx	Bleeding gums	☐Y	☐N	☐Hx
Bad Breath	☐Y	☐N	☐Hx	Dental Problems	☐Y	☐N	☐Hx
Sore throat/voice change	☐Y	☐N	☐Hx	Swollen glands	☐Y	☐N	☐Hx

Cardiovascular & Lungs

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

Skin

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

Musculoskeletal

Joint pain	☐Y	☐N	☐Hx	Joint stiffness/swelling	☐Y	☐N	☐Hx
Weakness of muscle/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				

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/Dribbling	☐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
Hepatitis ☐A	☐B or	☐C	☐No	HIV	☐Y	☐N	☐Hx

Other Infectious Diseases:_____

Endocrine

Glandular/hormone issue	☐Y	☐N	☐Hx	Heat/Cold Intolerance	☐Y	☐N	☐Hx
Excessive Thirst/urination	☐Y	☐N	☐Hx	Recent weight change	☐Y	☐N	☐Hx
Change in hat/glove size	☐Y	☐N	☐Hx	Skin becoming dryer	☐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				

Mental and Emotional Health

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

_____

All non-cancer related events

Hospitalizations (Reason/Year): _____

_____

Surgeries (Type/Year): _____

_____

Significant Injuries/Falls: _____

_____

Serious Illnesses (Cause/Year): _____

_____

Gastrointestinal

Does food generally sit well in your stomach and digest without difficulty? ☐Yes ☐No

Do you have gas or abdominal bloating? ☐Yes ☐No

How often do you have a bowel movement? (Please choose one) Daily_____ or _____Weekly

Are your bowel movements generally formed or loose?_____ Color?_____

Do you need to strain to have a bowel movement? ☐Yes ☐No

Do you have hemorrhoids or any other rectal or bowel problems? ☐Yes ☐No

If yes explain:

_____

_____

Problems: Past & Present

Abdominal pain	☐No	☐Yes, in the past	☐Yes, Currently
Acid Indigestion	☐No	☐Yes, in the past	☐Yes, Currently
Acid Reflux	☐No	☐Yes, in the past	☐Yes, Currently
Blood in stool	☐No	☐Yes, in the past	☐Yes, Currently
Change in bowel movement	☐No	☐Yes, in the past	☐Yes, Currently
Colitis	☐No	☐Yes, in the past	☐Yes, Currently
Constipation	☐No	☐Yes, in the past	☐Yes, Currently
Diarrhea	☐No	☐Yes, in the past	☐Yes, Currently
Diverticulitis	☐No	☐Yes, in the past	☐Yes, Currently
Helicobacter Pylori	☐No	☐Yes, in the past	☐Yes, Currently
Hemorrhoids	☐No	☐Yes, in the past	☐Yes, Currently
Hiatal Hernia	☐No	☐Yes, in the past	☐Yes, Currently
Irritable Bowel Syndrome	☐No	☐Yes, in the past	☐Yes, Currently
Liver/ Gallbladder disease	☐No	☐Yes, in the past	☐Yes, Currently
Loss of appetite	☐No	☐Yes, in the past	☐Yes, Currently
Nausea or vomiting	☐No	☐Yes, in the past	☐Yes, Currently
Ulcers	☐No	☐Yes, in the past	☐Yes, Currently
Parasites	☐No	☐Yes, in the past	☐Yes, Currently

When diagnosed? _____ Where diagnosed? _____

How diagnosed? _____

How treated? _____

_____

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: _____

_____

_____

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):

_____

_____

_____

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

_____

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.

☐ No ☐ Yes Please list: _____

_____

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? _____

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 _____

Female Gynecological History

Age menses began_____Number of flow days_____Cycle length_____

Date of last menstrual period_____

Do you experience excessive cramping? ☐Yes ☐No

Do you experience a heavy flow? ☐Yes ☐No

Do you experience bleeding or spotting between periods? ☐Yes ☐No

Do you experience any abnormal discharge? ☐Yes ☐No

Are your cycles regular? ☐Yes ☐No

Do you experience symptoms of premenstrual tension? ☐Yes ☐No

Do you have a history of ovarian cysts, uterine fibroids, and/or endometriosis? ☐Yes ☐No

Date of last PAP:_____ ☐Normal ☐Abnormal

Have you ever had an abnormal PAP and, if so, when? _____

Please list the number of each of the following:

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

Type of birth control used: _____

Difficulty conceiving ☐Yes ☐No Pain on intercourse ☐Yes ☐No

Menopausal symptoms (list): _____

Sexually active ☐Yes ☐No Having sexual difficulties ☐Yes ☐No

Breasts

I do self-exams regularly ☐ Yes ☐ No ☐ in past

Breast changes or lumps ☐ Yes ☐ No ☐ in past

Any pain or tenderness ☐ Yes ☐ No ☐ in past

Breast/Nipple discharge ☐ Yes ☐ No ☐ in past

Do you have implants ☐ Yes ☐ No ☐ in past

Have you ever had a mammogram? ☐ Yes ☐ No When? _____ Results: ☐ Normal ☐ Abnormal

Anything else you would like to add: _____

_____

_____

_____