Health History Questionnaire

Please take the time to fill out this questionnaire carefully. If you have any questions, ask for assistance. If you have concerns that are not listed, make note of them in the comments section. The completed form will greatly assist us in providing a thorough evaluation of your health.

Confidential Patient Profile

Name:_____ Age: _____ Date of Birth: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: Home ( ) _____ Work ( ) _____ E-mail:_____

Occupation: _____ How did you hear about us? _____

Emergency Contact: _____ Relationship: _____ Day Phone: ( ) _____

Chief Complaint: In this section please list in order of importance your health concerns.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Current Medication List: In this section please list all pharmaceutical medication(s) that you are currently taking along with dosage and frequency

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Are you allergic to any medications? Yes _____ No _____

If "Yes", please list: _____

What happens when you have an allergy attack to medication? _____

Hospitalizations: Include reason, year and duration: _____

_____

_____

Current Supplement List: In this section please include all homeopathics, herbs, vitamins, minerals you are currently taking with dosage.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Social History:

Are you currently: Married _____ Divorced _____ Single _____ Long-Term Relationship _____ Widowed _____

Number of children and ages? _____

Date of last physical exam: _____ **Men**: Date of last prostate exam: _____

Have you traveled outside the US in the past year? Yes _____ No ____ If yes, where? _____

Health Habits:

	Yes	No	If "yes", how long or how much per week?
Do you exercise?			
Do you smoke tobacco? Now or in the past.			
Do you drink alcohol?			
Do you use recreational drugs?			
Do you drink coffee, soda or black tea?			
Do you drink "diet" sodas or eat "diet" foods?			
Are you familiar with "safe sex" practices?			
Do you follow any dietary modifications?			If yes, please describe:

Food or Environmental Allergies: List any known allergens here:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Past Medical History: In this section, please check the appropriate box that applies to you.

Illness	Now	Past	Never	Illness	Now	Past	Never
Allergies				Gout			
ADD/ADHD				Headaches or Migraine			
Alcoholism				Heart Murmur			
Altered sense: (e.g. taste, smell)				Hemorrhoids			
Anemia				High Blood Pressure			
Anxiety/Depression				HIV/AIDS			
Arthritis				Hyperthyroid			
Asthma				Hypothyroid			
Bleeding Difficulties				Injury (Serious)			
Blood in Stools				Kidney Disease			
Blurred Vision				Liver Disease/Jaundice			
Cancer				Low blood sugar (hypoglycemia)			
Candida (yeast) infection				Numbness/Tingling			
Chemical Sensitivities				Obesity			
Chronic Fatigue				Other (specify)			
Colitis				Ovarian Cysts			
Diabetes				Pneumonia			
Dizziness/Vertigo				Post Traumatic Stress Disorder			
Eczema				Recreational Drug use			
Emphysema				Rheumatoid Arthritis			
Fainting				Schizophrenia			
Fibromyalgia				Seizure/epilepsy			
Genital Herpes				Stroke			
GI Ulcers				Syphilis			
Glaucoma				Tuberculosis			

Family History: Complete for those applicable and check box if yes for appropriate relation.

	Mother	Father	Brother(s)	Sister(s)	Grandparents	Child
Age if living						
Age at death						
Cause of death						
Alcoholism						
Alzheimer's Disease						
Anemia						
Asthma, Allergies, Hives						
Autoimmune Disease						
Cancer						
Depression/Suicide						
Diabetes						
Epilepsy						
Gastrointestinal Disease						
Glaucoma						
Heart Disease						
High Blood Pressure						
HIV/AIDS						
Mental Illness						
Obesity						
Parkinson's Disease						
Syphilis						
Tuberculosis						

Review of Systems: In this section, please check the appropriate box.

	Yes, Currently	Yes, in Past	Never
General:			
Do you usually feel tired or worn out?			
Have you recently been more thirsty than normal?			
Has there been any unusual weight gain or loss recently?			
Do you perspire a lot?			
Do you prefer warm?			
Do you prefer cold?			
Skin/Hair/Nails			
Have you noticed any changes in the color of your skin?			
Have you noticed any skin rashes or itching?			
Have you noticed any unusually dry skin?			
Have you noticed any growth on your skin that bothers you?			
Have you noticed any sores or wounds that do not heal?			
Have you noticed any change in color or size or warts?			
Do you have dry skin or brittle nails?			
Eyes:			
Have you had any pain in your eyes?			
Have you had any blurry vision?			
Are you nearsighted or farsighted (circle one)			
Have you noticed any change in your vision?			
Do you often have itchy eyes?			
Have you noticed any redness or burning in your eyes?			
Do you see halos around lights?			
Ears, Nose, Throat:			
Do you have any difficulty hearing?			
Do you have any ringing or buzzing in your ears?			
Do you have earaches or discharge from your ears?			
Do you have a lot of nasal stuffiness or sinusitis?			
Do you have drainage down the back of your throat?			

Ears, Nose and Throat (cont.)	Yes, Now	Yes, In Past	Never
Do you experience frequent or severe nosebleeds?			
Do you have any lumps in your throat?			
Do you experience sore tongue or mouth?			
Do you have bleeding or easily infected gums?			
Do have excessive saliva?			
Do you have bad breath?			
Respiratory			
Do you have frequent chest colds?			
Do you have a constant or bothersome cough?			
Do you cough up blood?			
Do you have sputum or phlegm between colds?			
Do you have any difficulty breathing?			
Have you noticed any wheezing or whistling?			
Cardiovascular			
Do you have pain, tightness or pressure in front or back of your chest?			
If yes, is it when walking fast, working hard or when excited?			
Have you ever had an abnormal EKG?			
Do you have swelling of your feet or ankles?			
Do you have cramps in the calf muscles when you walk?			
Do you ever awaken at night with difficulty breathing?			
Do you need to sleep on more than one pillow?			
Does your heart ever beat fast or irregularly?			
Do your fingers or toes ever get cold, become numb or blue?			
Gastrointestinal			
Have you recently had any change in your eating habits?			
Are there any foods that give you upset or pain?			
Have you recently experienced nausea or vomiting?			
Do you have excessive gas? (burping or passing gas?)			
Have you ever vomited blood?			
Do you have a lot of indigestion, heartburn or reflux?			
Have you recently experienced any trouble swallowing?			
Do you experience constipation?			
Do you experience diarrhea?			
Do you have a poor appetite or are easily satiated?			
Have you ever had blood in your stools?			
Do you have hemorrhoids?			
Do you take laxatives regularly?			
Do you feel bloated after meals?			
Do you experience abdominal pain or cramping?			
Genitourinary			
Do you have any burning or pain on urination?			
Do you have any change in frequency of urination?			
Have you experienced urinary incontinence?			
Do you get up at night to urinate?			
Do you have a problem dribbling urine?			
Have you ever passed blood in your urine?			
Do you have frequent bladder or kidney infections?			
Men, do you have prostate trouble?			
Men, have you ever experienced erectile dysfunction?			
Musculoskeletal			
Do you experience regular backpain?			
Do you have pain in your legs or feet?			
Have you ever been diagnosed with scoliosis?			
Do you have joint pain or stiffness?			
Do you have trouble walking or using your hip or knee joints?			
Do you experience regular pain in your body? (specify)			

Central Nervous System	Yes, Now	Yes, In Past	Never
Do you have frequent or severe headaches?			
Do you have dizzy spells, faintness or lightheadedness?			
Do you sometimes lose track of what happens around you for a short time?			
Do you sometimes lose the ability to speak for a few seconds?			
Have you fainted, blacked out or lost consciousness?			
Do you consider yourself a nervous person?			
Do you have trouble remembering recent events?			
Have you ever had convulsions or fits?			
Do you experience insomnia?			
Have you been highly emotional lately?			
Psychological/mental status			
Do you experience depression?			
Do you experience anxiety or panic attacks?			
Have you ever been hospitalized for a psychological condition?			
Have you ever had any suicidal attempts?			
Do you have suicidal thoughts?			
Do you experience excessive restlessness?			
Do you experience mental confusion?			
Are you critical of yourself?			
Are you critical of others?			
Do you experience mood swings?			
Do you experience loneliness?			
Have you ever been diagnosed with a psychological condition?			
Environmental Exposure			
Have you ever worked around known toxic chemicals?			
Have you ever been exposed to chemical solvents?			
Do you use oil paints?			
Do you have mercury amalgam fillings?			
Have you ever been excessively exposed to toxic fumes? Eg gasoline, exhaust fumes, burning of toxic synthetic materials etc.			
Do you have any know exposure to any heavy metals?			
Are you a gardener?			

Additional Comments:

Women Only: Gynecology and Pregnancy

Please specify the number of: Births _____ Miscarriages _____ Abortions _____

Age at first period: _____ Age at Menopause: _____ Menopausal symptoms: _____

Regular or Irregular cycles? Circle one. Duration of flow (days): _____ Time between cycles: _____

Flow (check one):

- ❑ Excessive
- ❑ Moderate
- ❑ Scanty

PMS (check one):

- ❑ Yes
- ❑ No

Symptoms: _____

Cramps (check one):

- ❑ Severe
- ❑ Mild
- ❑ None

Date of last period: _____ Method of birth control: _____

- ❑ Breast lumps
- ❑ Breast tenderness
- ❑ History of genital warts
- ❑ Mother or sister with breast cancer
- ❑ Nipple discharge
- ❑ Pain during intercourse
- ❑ Pain during orgasm
- ❑ Abnormal Vaginal discharge
- ❑ Vaginal dryness
- ❑ Vaginal itching
- ❑ Vulvar itching
- ❑ Water retention
- ❑ Pass clots with periods
- ❑ Past or current use of IUD
- ❑ Perform self breast examination regularly
- ❑ Spotting between periods
- ❑ History of abnormal pap?
- ❑ Infertility problems