Health History Questionnaire

Personal Information

Name _______________________________________Age _____Birthdate __________________
Height ______ Weight _____
Occupation ____Do you enjoy the work you do? Y N
Phone (best number you can be reached) ____
Address ____
Email address ____
Would you like to receive health tips and notices (meetings, new services, product info)?
Yes No
Referred by? ____

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

1. ______________________________ 5. _________________________________
2. ______________________________ 6. _________________________________
3. ______________________________ 7. _________________________________
4. ______________________________ 8. _________________________________

Prior Medical Diagnoses (and their treatment)

1. ____
2. ____
3. ____
4. ____

Prior surgery/s (including dental surgery), trauma or accident:

1. ____
2. ____
3. ____
4. ____

Current Medication List: Please list all pharmaceutical medication(s) that you are currently taking along with dosage and frequency.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. _________________________________
6. _________________________________
7. _________________________________
8. _________________________________

Are you allergic to any medications: Y N

If "yes", please list: ____

What happens when you have an allergic reaction to medication?

____

____

Have you ever been treated with antibiotics: Y N How many times? _____________

Current Supplement List: Please include all homeopathics, herbs, vitamins, minerals you are currently taking with dosage.

1. _____________________________
2. _____________________________
3. _____________________________
4. _____________________________
5. _____________________________
6. __________________________________
7. __________________________________
8. __________________________________
9. __________________________________
10. __________________________________

How much sleep do you get each night on an average? _____

Do you stay asleep? Y N If no, what time do you typically awaken? ________________

Do you know what typically awakens you? (pain, hunger, hot flashes, anxiety, racing thoughts)

If awakened do you have trouble falling back to sleep? Y N

What time do you typically awaken in the morning? ______Is it difficult to get out of bed? Y N

Do you work shift work? Y N What shift and does it vary week to week? ____________ Y N

Sleep aids used? (medications, sound machine, TV, alcohol, supplements) _______________

How often do you exercise? _________ for how long? ___________

What do you do for exercise? ____

How often do you have a bowel movement? _____________________________________

Do you use laxatives? Y N

Do you or have you used any of the following:

	Never	Past	Daily	Weekly
Smoking	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Coffee or black tea	☐	☐	☐	☐
Energy drinks	☐	☐	☐	☐
Pain Medication	☐	☐	☐	☐
Laxative	☐	☐	☐	☐
Diet Pills	☐	☐	☐	☐
Soda/Sugary drinks	☐	☐	☐	☐

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

Number of children and ages? ____________________

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

With whom do you live? (including roommates, friends, partner, spouse, children, parents, relatives, pets)

Relationship	Age	Relationship	Age

What are the major stressors in your life? ____________________

What to you do to relax/relieve stress? ____________________

What interests/hobbies do you have? ____________________

Describe your energy level on a scale of 1-10 (10 high energy): Morning ______ Afternoon: ________ Evening: __________

Describe your sleep pattern (e.g., restful, interrupted etc.): ____________________

Nutrition

How many meals do you generally eat per day? ______ Do you skip meals? ______ How many servings of fruit per day? ______

How many servings of vegetables do you consume each day? (Svg: 1C raw, $\frac{1}{2}$ C cooked) ____________________

Are you currently on a special diet? Foods you avoid? Please explain. ____________________

How would you describe your relationship with food? What motivates you to eat or not?

____

____

How often do you eat out? ______________ Who prepares meals at home? ____________________

Do you eat breakfast? Y N If so, what___________________________________
____
When you have breakfast, is it at home? Y N If not, where?
____

Mid-Morning Snack? Y N If so, what? ___________________________________

Do you usually eat lunch? Y N If so, what?
____
____
Do you eat lunch at home? Y N If not, where?
____

Mid-Afternoon Snack? Y N If yes, what?
____

Do you usually eat an evening meal? Y N If so, what?
____
____
When you have your evening meal is it at home? Y N If not, where?
____

Do you use any meal substitutes, such as Slim-Fast, etc.? Y N If so, what?
____
How much water do you drink each day? _________________________________
What kind of water do you drink? (well, tap, distilled, reverse osmosis, bottled…etc.)
____

What foods do you crave?
____
What foods do you avoid?
____

Do you use sugar substitutes? Y N
Do you chew gum? Y N If yes, what kind? ______________________________
Do you use breath mints? Y N If yes, what kind? ___________________________

Family History

Indicate if a close relative (parent, child, sibling, grandparent) has had any of the following & indicate which member:

	NO	YES	Member
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Asthma/allergies/hives	☐	☐	
Alzheimer's	☐	☐	
Depression/suicide	☐	☐	
Other mental illness	☐	☐	
Drug/Alcoholism	☐	☐	
Kidney Disease	☐	☐	
Multiple Sclerosis (MS) or Parkinson's	☐	☐	
Autoimmune condition	☐	☐	
Epilepsy	☐	☐	
Gastrointestinal Diseases	☐	☐	
Glaucoma	☐	☐	
HIV/AIDS	☐	☐	
Obesity	☐	☐	
Syphilis	☐	☐	
Tuberculosis	☐	☐	

Review of Systems

Mental/Emotional	Currently	Past	Never
Depression	☐	☐	☐
Mood swings	☐	☐	☐
Anxiety/nervousness	☐	☐	☐
Seasonal depression	☐	☐	☐
Consider or attempted suicide	☐	☐	☐
Poor concentration	☐	☐	☐
Memory problems	☐	☐	☐
Schizophrenia	☐	☐	☐
PTSD	☐	☐	☐
Bipolar	☐	☐	☐
Endocrine			
Hypo/hyperthyroid	☐	☐	☐
Heat or cold intolerance	☐	☐	☐
Hypoglycemia/Low blood sugar	☐	☐	☐
Diabetes	☐	☐	☐
Increased thirst	☐	☐	☐
Night sweats	☐	☐	☐
Increased hunger	☐	☐	☐
Fatigue	☐	☐	☐
Headaches	☐	☐	☐
Unusual weight gain/loss	☐	☐	☐
Overweight or Obesity	☐	☐	☐
Neurological			
Seizures	☐	☐	☐
Paralysis	☐	☐	☐
Muscle weakness	☐	☐	☐
Numbness or tingling	☐	☐	☐

Neurological	Currently	Past	Never
Loss of memory	☐	☐	☐
Easily stressed	☐	☐	☐
Vertigo/dizziness	☐	☐	☐
Loss of balance	☐	☐	☐
Skin/Hair/Nails			
Rashes/Hives	☐	☐	☐
Brittle nails	☐	☐	☐
Eczema	☐	☐	☐
Dry skin	☐	☐	☐
Moles/growths/warts	☐	☐	☐
Athletes foot	☐	☐	☐
Itching	☐	☐	☐
Color changes	☐	☐	☐
Hair loss	☐	☐	☐
Head			
Migraines	☐	☐	☐
Jaw problems/TMJ	☐	☐	☐
Head injury	☐	☐	☐
Eyes			
Spots in eyes	☐	☐	☐
Cataracts	☐	☐	☐
Impaired vision	☐	☐	☐
Glaucoma	☐	☐	☐
Near/Farsighted	☐	☐	☐
Blurriness/hallows	☐	☐	☐
Eye pain/strain	☐	☐	☐
Tearing/dryness/redness	☐	☐	☐

Ears	Currently	Past	Never
Difficulty hearing	☐	☐	☐
Ringing/buzzing	☐	☐	☐
Ear aches/pain	☐	☐	☐
Excess ear wax	☐	☐	☐
Frequent infections	☐	☐	☐

Nose	Currently	Past	Never
Stuffiness	☐	☐	☐
Nose bleeds	☐	☐	☐
Hay fever/rhinitis	☐	☐	☐
Sinus problems	☐	☐	☐
Loss of smell	☐	☐	☐
Post nasal drip	☐	☐	☐

Mouth/Throat	Currently	Past	Never
Frequent sore throat	☐	☐	☐
Chronic sore throat	☐	☐	☐
Teeth grinding	☐	☐	☐
Silver fillings	☐	☐	☐
Bleeding gums	☐	☐	☐
Hoarse voice	☐	☐	☐
Dental cavities	☐	☐	☐
Root canals	☐	☐	☐
Loss of sense of taste	☐	☐	☐

Neck	Currently	Past	Never
Lumps	☐	☐	☐
Swollen glands	☐	☐	☐
Goiter	☐	☐	☐
Pain or stiffness	☐	☐	☐

Lungs	Currently	Past	Never
Cough	☐	☐	☐
Phlegm	☐	☐	☐
Spitting up blood	☐	☐	☐
Wheezing	☐	☐	☐
Emphysema	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Pneumonia	☐	☐	☐
Tuberculosis	☐	☐	☐
Shortness of breath (SOB)	☐	☐	☐
SOB at night	☐	☐	☐
Difficulty breathing	☐	☐	☐
Pain on breathing	☐	☐	☐

Cardiovascular	Currently	Past	Never
Stroke	☐	☐	☐
Poor circulation	☐	☐	☐
Heart disease	☐	☐	☐
Angina	☐	☐	☐
High/low blood pressure	☐	☐	☐
Murmurs	☐	☐	☐
Swollen ankles	☐	☐	☐
Fainting	☐	☐	☐
Varicose veins	☐	☐	☐
Palpitations/fluttering	☐	☐	☐
Rheumatic fever	☐	☐	☐
Chest pain	☐	☐	☐
Irregular heart beat	☐	☐	☐

Gastrointestinal	Currently	Past	Never
Heartburn	☐	☐	☐
Change in appetite	☐	☐	☐
Blood/mucous in stool	☐	☐	☐
Belching or Flatulence	☐	☐	☐
Nausea/vomiting	☐	☐	☐
Constipation	☐	☐	☐
Ulcers	☐	☐	☐
Loose stools/Diarrhea	☐	☐	☐
Jaundice (yellow skin)	☐	☐	☐
Liver or gallbladder disease	☐	☐	☐
Black stool	☐	☐	☐
Hemorrhoids	☐	☐	☐
Abdominal pain or cramps	☐	☐	☐
Troubles swallowing	☐	☐	☐
Travelers Diarrhea/Parasites	☐	☐	☐

Urinary	Currently	Past	Never
Pain on urinations	☐	☐	☐
Increased frequency	☐	☐	☐
Inability to hold urine	☐	☐	☐
Kidney stones	☐	☐	☐
Frequent infections	☐	☐	☐
Urgency	☐	☐	☐
Urination at night	☐	☐	☐

Musculoskeletal	Currently	Past	Never
Joint pain/stiffness	☐	☐	☐
Arthritis	☐	☐	☐
Broken bones	☐	☐	☐
Sciatica	☐	☐	☐

	Currently	Past	Never
Gout	☐	☐	☐
Muscle weakness	☐	☐	☐
Muscle spasms/cramps	☐	☐	☐

Peripheral Vascular			
Cold hands & feet	☐	☐	☐
Anemia	☐	☐	☐
Deep leg pain	☐	☐	☐
Thrombophlebitis	☐	☐	☐
Easy bleeding/bruising	☐	☐	☐

Female	Currently	Past	Never
PCOS	☐	☐	☐
Ovarian Cysts	☐	☐	☐
STI	☐	☐	☐
Fibroids	☐	☐	☐

Length of cycle: ______ Length of menses: _____

Age of first menstruation: ____________________

Are cycles regular	YES ☐	NO ☐
HIV Positive	YES ☐	NO ☐
Breakthrough bleeding	YES ☐	NO ☐
Acne	YES ☐	NO ☐
Menstrual cramps	YES ☐	NO ☐
Breast tenderness	YES ☐	NO ☐
Mood changes	YES ☐	NO ☐
Bloating	YES ☐	NO ☐

Sexual orientation: ____________________________

Date of last PAP & physical exam: _____________

Children: ________ # Pregnancies: _________

Miscarriages: ________ # Abortions: ________