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Name_____ Date_____

Age_____ Date of Birth_____ ☐ Male ☐ Female

Address_____

City _____ State_____ Zip code_____

Phone #_____ Cell # _____

Occupation_____ Hours per week_____ ☐ Retired

Employer_____

Employer Address_____

Education_____

Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partnership

Live with: ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone

Next of Kin or who to reach in an emergency:_____

Relationship_____ Phone #_____

How did you hear about our clinic?_____

FAMILY HISTORY	**FATHER**	**MOTHER**	**BROTHERS**	**SISTERS**	**SPOUSE**	**CHILD**
Age (if living)						
Health (G=good P=poor)						
Age at Death (if deceased)						
Cause of Death						
Check all applicable:						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma/Hay fever/Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						

HEALTH HISTORY QUESTIONNAIRE

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Please mark anything you don't understand with a question mark.

Are you currently receiving healthcare? Y N

If yes, where and from whom?_____

If no, when and where did you last receive health care?_____

What was the reason?_____

What are your most important health problems? List as many as you can in order of importance.

1_____

2_____

3_____

4_____

5_____

Do you have any contagious diseases at this time? Y N

If yes, what?_____

For the following sections, please check all that apply:

CHILDHOOD ILLNESSES

☐ Scarlet fever ☐ Diptheria ☐ Rheumatic fever

☐ Mumps ☐ Measles ☐ German Measles

HOSPITALIZATION AND SURGERIES

What hospitalizations or surgeries have you had?_____

_____

X-RAYS AND SPECIAL STUDIES

X-rays, CAT scans or other studies you have had:_____

_____

☐ Electrocardiogram ☐ Electroencephalogram

IMMUNIZATIONS

☐ Polio ☐ Pertussis

☐ Tetanus Shot ☐ Diphtheria

☐ Measles / Mumps / Rubella ☐ Other_____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs?_____

_____

_____

Any foods?_____

_____

_____

CURRENT MEDICATIONS

Do you take or use:

☐ Laxatives ☐ Pain relievers ☐ Antacids

☐ Cortisone ☐ Appetite suppressants ☐ Antibiotics

☐ Tranquilizers ☐ Thyroid medication ☐ Sleeping pills

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking?

1_____ 7_____

2_____ 8_____

3_____ 9_____

4_____ 10_____

5_____ 11_____

6_____ 12_____

_____

_____

TYPICAL FOOD INTAKE

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

REVIEW OF SYSTEMS

GENERAL

Current Weight _____lbs Weight one year ago:_____lbs

Maximum Weight:_____ When? _____Height:_____

When during the day is your energy the best? _____Worst? _____

Please check all conditions you have now or have had in the past:

EMOTIONAL

- ☐ Treated for emotional problems
- ☐ Mood Swings
- ☐ Considered / Attempted suicide
- ☐ Depression
- ☐ Anxiety of nervousness
- ☐ Tension

ENDOCRINE

- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Heat or cold intolerance
- ☐ Diabetes
- ☐ Excessive hunger
- ☐ Seasonal depression

IMMUNE

- ☐ Vaccinations
- ☐ Chronic Fatigue Syndrome
- ☐ Chronically swollen glands
- ☐ Reactions to vaccinations
- ☐ Chronic infections
- ☐ Slow wound healing

NEUROLOGIC

- ☐ Seizures
- ☐ Muscle weakness
- ☐ Loss of memory
- ☐ Vertigo or dizziness
- ☐ Paralysis
- ☐ Numbness or tingling
- ☐ Easily stressed
- ☐ Loss of balance

SKIN

- ☐ Rashes
- ☐ Acne, Boils
- ☐ Color Change
- ☐ Lumps
- ☐ Eczema, Hives
- ☐ Itching
- ☐ Perpetual Hair Loss
- ☐ Night Sweats

HEAD

- ☐ Headaches
- ☐ Migraines
- ☐ Head Injury
- ☐ Jaw / TMJ problems

EYES

- ☐ Spots in eyes
- ☐ Impaired vision
- ☐ Blurriness
- ☐ Color blindness
- ☐ Double vision
- ☐ Cataracts
- ☐ Glasses or contacts
- ☐ Eye pain / strain
- ☐ Tearing or dryness
- ☐ Glaucoma

Please check all conditions you have now or have had in the past:

NOSE AND SINUSES

- ☐ Frequent colds
- ☐ Stuffiness
- ☐ Sinus problems
- ☐ Nose Bleeds
- ☐ Hayfever
- ☐ Loss of smell

MOUTH AND THROAT

- ☐ Frequent sore throat
- ☐ Teeth grinding
- ☐ Gum problems
- ☐ Dental cavities
- ☐ Copious saliva
- ☐ Sore tongue / lips
- ☐ Hoarseness
- ☐ Jaw clicks

NECK

- ☐ Lumps
- ☐ Goiter
- ☐ Swollen glands
- ☐ Pain or stiffness

RESPIRATORY

- ☐ Cough
- ☐ Spitting up blood
- ☐ Asthma
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Pain on breathing
- ☐ Shortness of breath at night
- ☐ Tuberculosis
- ☐ Sputum
- ☐ Wheezing
- ☐ Bronchitis
- ☐ Pleurisy
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Shortness of breath lying down

CARDIOVASCULAR

- ☐ Heart disease
- ☐ High / Low Blood Pressure
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Rheumatic Fever
- ☐ Swelling in ankles
- ☐ Angina
- ☐ Murmurs
- ☐ Fainting
- ☐ Palpitations / Fluttering
- ☐ Chest pain

GASTROINTESTINAL

- ☐ Trouble swallowing
- ☐ Change in thirst
- ☐ Nausea
- ☐ Vomiting blood
- ☐ Blood in stool
- ☐ Pain or cramps
- ☐ Belching or passing gas
- ☐ Black stools
- ☐ Jaundice (yellow skin)
- ☐ Liver Disease

Bowel movements – How often?_____

Is this a change?_____

- ☐ Vomiting
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gall Bladder disease
- ☐ Ulcer
- ☐ Hemorrhoids

URINARY

- ☐ Pain on urination
- ☐ Frequency at night
- ☐ Frequent infections
- ☐ Increased frequency
- ☐ Inability to hold urine
- ☐ Kidney stones

MALE REPRODUCTION

- ☐ Hernias
- ☐ Testicular pain
- ☐ Venereal disease
- ☐ Are you sexually active
- ☐ Sexual orientation_____
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Birth control Type:_____
- ☐ Testicular masses
- ☐ Prostate disease
- ☐ Discharge or sores
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Condyloma
- ☐ Herpes
- ☐ Syphilis

FEMALE REPRODUCTION/BREASTS

Age of first menses _____

Length of cycle _____ days

Duration of menses _____ days

- ☐ Painful menses
- ☐ Heavy or excessive flow
- ☐ PMS

If yes, symptoms:_____

_____

- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Difficulty conceiving
- ☐ Cervical Dysplasia
- ☐ Sexual difficulties
- ☐ Gonorrhea
- ☐ Herpes

Are you sexually active? Y N

Do you do breast self exams? Y N

Sexual orientation _____

Are cycles regular Y N

- ☐ Bleeding between cycles
- ☐ Pain during intercourse
- ☐ Clotting
- ☐ Discharge
- ☐ Birth control _____

Number of pregnancies _____

Number of live births _____

Number of miscarriages _____

Number of abortions _____

- ☐ Menopausal symptoms
- ☐ Abnormal PAP
- ☐ Chlamydia
- ☐ Condyloma
- ☐ Syphilis
- ☐ Breast pain / tenderness
- ☐ Breast lumps
- ☐ Nipple discharge

MUSCULOSKELETAL

- ☐ Joint pain or stiffness
- ☐ Broken bones
- ☐ Muscle spasms or cramps
- ☐ Arthritis
- ☐ Weakness
- ☐ Sciatica

BLOOD / PERIPHERAL VASCULAR

- ☐ Easy bleeding or bruising
- ☐ Deep leg pain
- ☐ Varicose veins
- ☐ Anemia
- ☐ Cold hands / feet
- ☐ Thrombophlebitis

HABITS

Main interests and hobbies?_____

Do you exercise? Y N If so, what kind?_____

How often?_____

Do you have a religious or spiritual practice? Y N If yes, what?_____

Do you eat three meals a day? Y N

- ☐ Sleep well
- ☐ Enjoy your work
- ☐ Watch television - How many hours? _____
- ☐ Take vacations
- ☐ Have a supportive relationship
- ☐ Have ever been treated for drug dependence
- ☐ Use recreational drugs
- ☐ Been treated for alcoholism
- ☐ Drink coffee
- ☐ Drink black tea
- ☐ Drink cola
- ☐ Eat sugar
- ☐ Average 6 – 8 hrs sleep
- ☐ Awaken rested
- ☐ Spend time outside
- ☐ Read - How many hours? _____
- ☐ Any major traumas?
- ☐ Have a history of abuse
- ☐ Use alcoholic beverages
- ☐ Use Tobacco
- ☐ Smoked previously How many years?_____
  How many packs a day? _____
- ☐ Eat out often
- ☐ Go on diets often
- ☐ Eat salt

How does your condition affect you?_____

_____

What do you think is happening?_____

_____

Why?_____

_____

What do you feel needs to happen for you to get better?_____

_____

What do you enjoy most in your life?_____

_____

How much change are you willing to make at this time for improving your health? MINIMAL SOME COMPLETE

Is there any information about your health you would like to add?_____

_____

_____

_____

_____