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HEATH HISTORY QUESTIONNAIRE

DATE:_____

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential.

Name: _____ Age: _____ Birthdate: _____

Address: _____City: _____State:_____ Zip:_____

Home/Cell Phone: _____msg ok?____ Work: _____

Email Address: _____

Is it okay to use email as a reminder and response to your questions? _____

Weight: _____ Weight one-year ago: _____ Highest Weight: _____ Lowest weight in last 5 years _____

Height: _____ Occupation: _____

Gender/Orientation:_____

Marital Status: S M D W Children: Yes No
How long? Names & Ages:

Partner's Name: _____

Emergency Contact: _____Phone: _____

How did you hear about us? _____

Primary Care Provider: _____ Other Medical Providers: _____

Present Health Concerns: In your opinion, what are your most significant health concerns in the order of importance?

1._____

2._____

3._____

4._____

Health History:

Health as a child: _____ GOOD _____ FAIR _____ POOR

Where did you live mostly as a child? _____

Allergies (food, drugs, animals or airborne):_____

Hospitalizations/Surgeries and year: _____

_____

Other Serious Illnesses/Injuries and year: _____

_____

_____

_____

PLEASE BRING ALL YOUR BOTTLES OF VITAMINS AND SUPPLEMENTS!

List all current prescription medications and supplements:

_____ _____

_____ _____

_____ _____

Exercise Regularly? ___ YES ___ NO What type? _____
HOW OFTEN?_____

Family Health History:

	YOUR		FATHER'S SIDE		MOTHER'S SIDE	
	Father	Mother	Father	Mother	Father	Mother
Age (if living)						
Age at death						
Health Problems						

Brother's Ages:_____ Health Problems: _____
Sister's Ages: _____ Health Problems: _____

Review of Symptoms: Please circle those that apply.

Skin
Rashes
Acne
Eczema
Changes in hair/nails
Other _____

Head
Headaches/Migraines
Head Injury
Other _____

Nose & Sinuses
Frequent Colds
Nose Bleeds
Stuffiness
Sinus Problems
Other _____

Neck
Swollen Glands
Pain/Stiffness
Other _____

Mouth & Throat
Sore Tongue
Sores in mouth/lips
Gum problems
Difficulty Swallowing
Hoarseness
Other _____

Eyes
Eye Pain
Tearing or Dryness
Double Vision
Vision Loss
Contacts/Glasses
Other _____

Ears
Impaired Hearing
Ringing
Earache
Dizziness
Other _____

Digestion
How many bowels movements
per day _____ or
in a week _____
Heartburn
Stomach Pain
Appetite change:
Nausea
Vomiting

Digestion - continued
Gas
Loose Stools
Constipation
H. Pylori Infections
Ever had a Colonoscopy Y N
Other _____

Circulation
Cold hands/feet
Varicose Veins
Other _____

Blood
Blood Type _____
Anemia – Low Red Blood Cells
Easy Bleeding/Bruising
Blood Clots
Other _____

Heart
Angina – Chest Pain
Murmurs
High Blood Pressure
Ankle Swelling
Heart Palpitations
Heart Skipping a Beat

Musculoskeletal
Joint Pain/Stiffness
Muscle Spasm/Cramps
Muscle Weakness
Other _____

Urinary
UTI's
Urination Pain
Night Frequency?
How often _____
Inability to Hold Urine
Other _____

Respiratory
Cough
Spitting up Blood
Asthma/Wheezing
Hay fever
Pneumonia
Shortness of Breath
Positive TB Test
Other _____

Neurologic
Fainting
Seizures
Paralysis
Muscle Weakness
Numbness/Tingling
Memory Loss
Hyperactivity
ADD/ADHD
Depression
Suicidal Tendencies

Endocrine
Thyroid Problem
Intolerance to Heat
Intolerance to Cold
Hypoglycemia
Excessive Thirst
Excessive Hunger
Weight gain or loss

Diet:
Typical Breakfast
_____
_____
_____
Lunch
_____
_____
_____
Dinner
_____
_____
_____

Male Reproduction
Sexually Active Y N
Hernias
Testicular Masses
Venereal Warts
Herpes
Discharge
Difficulty with Erection
Prostate Cancer
Prostate Enlargement
Other _____

History of Drug, Alcohol and Tobacco Use: If still using, how much?

Drugs	Yes	No	Past	How Often?	_____x Day _____x Week _____x Month
Tobacco	Yes	No	Past	How Often?	_____x Day _____x Week _____x Month
Alcohol	YES	NO	PAST	HOW OFTEN?	_____x Day _____x Week _____x Month
Coffee	YES	NO	PAST	HOW OFTEN?	_____x Day _____x Week _____x Month

Additional Information You Would Like to Include?
_____
_____
_____
_____

MEN PLEASE STOP HERE ☺

Female Reproduction

Sexually Active Y N
with women, men or both? Please circle.
Yeast Infections
Venereal Warts
Herpes
HPV
Other STI's: _____

Birth Control: _____
Currently pregnant? Y N
# of Pregnancies: _____

Age Menstruation Began: _____
Last Period Began: _____
How Many Days of Bleeding: _____
Number of Days Between Cycles: _____
For example: 28, 30, 60
Irregular Cycles: Y N
Heavy Cramping: Y N
Heavy Flow: Y N
Light Flow: Y N

Any PMS Symptoms? Y N
If yes, Circle all that apply:
Sugar Cravings
Headaches
Acne
Anger
Depression
Anxiety
Abdominal Bloating
Fluid Retention

Breast Tenderness
Other _____

Date of last Pap Smear: _____
Any Abnormal Pap Smears: Y N
If yes, what was the problem?
_____
_____

Breast Self-Examinations: Y N
Tenderness
Breast Implants – Saline or Silicone?
Lumps
Breast Biopsy Y N
Last Mammogram _____
Other _____

Are You In Peri (Around) Menopause? Y N
Are You In Menopause? Y N
If yes, how old were you when you stopped menstruating completely? _____
Age, if known, of Mother's Menopause: _____

Menopausal Symptoms? Y N
If yes, circle all that apply:
Night Sweats
Hot Flashes
Vaginal Dryness
Fatigue
Depression
Sleep Disturbances
Others _____