Health History Questionnaire

Please help me provide you with a thorough evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be kept absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to my attention which is not on this form, please note it in the Comments section. Thank you.

Name	Street
City	State, Zip
Phone (home)	(cell)
(work)	email
Place of birth	Date of birth
Marital status	Occupation
Family physician	Referred by
Emergency contact	Phone

Main problem(s) you would like me to help you with: _____

How long ago did this problem begin (be specific)? _____

Have you been given a diagnosis for this problem? _____

If so, what is the diagnosis? _____

What kinds of treatment have you tried? _____

Significant illnesses:

Cancer Heart Disease HIV/AIDS Hepatitis COPD Lyme Neurological condition
Autoimmune Disorder Endocrine disorder Congenital Disease CVA Other

Surgeries: _____

Significant trauma (auto accidents, falls, etc.): _____

Allergies: (drugs, chemicals, foods): _____

Family Medical History: (Heart Disease, Stroke, Diabetes, Seizures, Cancer, High Blood Pressure, etc.)

_____

Are your parents alive? _____ Do you have children? _____ How many? _____

Medicines taken within the last two months (incl. vitamins, drugs, herbs, etc.) _____

_____

Occupational stress (chemical, physical, psychological,etc.) _____

Do you have a regular exercise program? Please describe: _____

Have you ever been on a restricted diet? _____ What kind? _____

Please describe your average daily diet:

Morning Mid-day Evening

_____

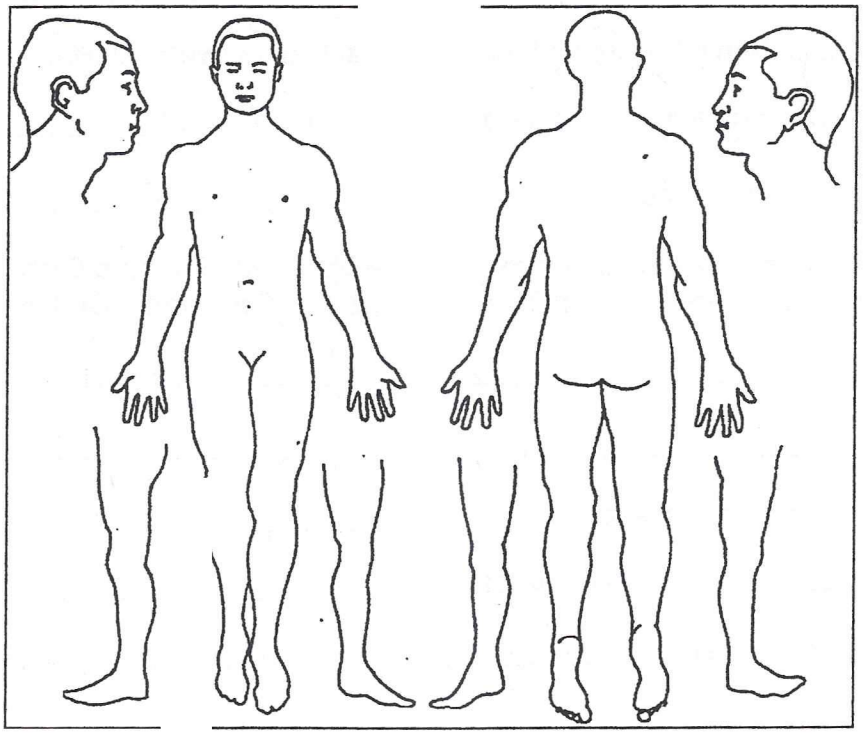
How many packs of cigarettes do you smoke a day? _____

How much coffee, tea, or cola do you drink per week? _____

How much alcohol do you drink per week? _____

Please describe any use of drugs for non-medical purposes: _____

Indicate painful or distressed areas (mark with an X)



Please check if you have experienced in the last three months:

General

o Poor appetite
o Fevers
o Sweat easily
o Localized weakness
o Bleed or bruise easily
o Sudden energy drop (time?)
o Poor sleeping
o Chills
o Tremor
o Poor balance
o Weight loss
o Strong thirst (hot or cold?)
o Fatigue
o Night sweats
o Cravings
o Change in appetite
o Weight gain
o Peculiar tastes or smells

Skin and hair

o Rashes
o Itching
o Change in texture of skin or hair
o Ulcerations
o Eczema
o Recent moles
o Hives
o Pimples
o Loss of hair

Any other skin or hair problems?

Head, eyes, ears, nose and throat

o Dizziness
o Glasses
o Poor vision
o Blurry vision
o Poor hearing
o Sinus problems
o Sores on lips, tongue or gums
o Teeth problems
o Concussions
o Eye strain
o Night blindness
o Floaters in eyes
o Earaches
o Nose bleeds
o Facial pain
o Headaches (where and when?)
o Migraine
o Eye pain
o Cataracts
o Ringing in ears
o Jaw clicks
o Recurrent sore throats
o Grinding teeth

Any other head or neck problems?

Cardiovascular

o High blood pressure
o Irregular heartbeat
o Swelling of hands
o Aneurysms
o Low blood pressure
o Cold hands or feet
o Phlebitis, thrombosis
o Clotting problems
o Chest pain
o Fainting
o Swelling of feet
o Difficulty in breathing

Any other heart or blood vessel problems?

Respiratory

o Cough
o Bronchitis
o Production of phlegm
o Coughing blood
o Pneumonia
o Difficulty in breathing when lying down
o Asthma
o Pain with a deep breath

Any other lung problems?

Gastrointestinal

o Nausea	o Vomiting	o Diarrhea
o Constipation	o Bloating	o Belching
o Black stool	o Blood in stool	o Reflux
o Bad breath	o Rectal pain	o Hemorrhoids
o Abdominal pain or cramps	o Flatulence	0 Chronic laxative use

Any other problems with your digestion?

Genito-urinary

o Pain on urination	o Frequent urination	o Blood in urine
o Urgent urination	o Incontinence	o Kidney stones
o Decrease in flow	o Impotence	o Sores on genitals
o Prostate problems	o Do you wake up to urinate? _____ How often? _____	

Any other problems with urination or your genitals?

Gynecological and reproductive

_____ Age at first menses	_____ Number of pregnancies	o Cysts or fibroids
_____ First day of last menses	_____ Number of births	o Breast lumps
_____ Period between menses	_____ Premature births	o Vaginal discharge
_____ Duration of menses	_____ Miscarriages	o Menopause (age ___)
o Irregular or painful periods	_____ Abortions	
o Heavy or light periods		
o Clots	Do you practice birth control?_____	
o PMS	What type and for how long? _____	

Musculoskeletal

o Neck pain	o Muscle pain	o Knee pain
o Back pain	o Muscle weakness	o Foot/ankle pain
o Hand/wrist pain	o Shoulder pain	o Hip pain

Any other problems with your joints or muscles?

Neuropsychological

o Dizziness	o Loss of balance	o Bad temper
o Areas of numbness	o Lack of coordination	o Depression
o Poor memory	o Seizures	o Anxiety
o Hypersensitive to odors	o Easily stressed	o History of abuse

Any other neurological or psychological problems? _____
Have you ever been treated for emotional problems? _____
Have you ever considered or attempted suicide? _____

Comments (please tell me of any other issues you would like to discuss) _____