Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(First, Middle, Last):* ☐ M ☐ F	**Date of Birth:**
Occupation	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Reason for today's visit:	
Please list any current health problems for which you are being treated:	
What types of therapies have you tried for these problem(s) or to improve your health over-all: ☐ Diet Modification ☐ Fasting ☐ Vitamins/Mineral Supplements ☐ Herbs ☐ Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs ☐ Other _____	

Do you experience any of these general symptoms EVERY DAY?				
☐ Debilitating Fatigue ☐ Depression ☐ Disinterest in Sex ☐ Disinterest in Eating	☐ Shortness of Breath ☐ Panic Attacks ☐ Headaches ☐ Dizziness	☐ Insomnia ☐ Nausea ☐ Vomiting ☐ Diarrhea	☐ Constipation ☐ Fecal Incontinence ☐ Urinary Incontinence ☐ Low Grade Fever	☐ Chronic Pain/Inflammation ☐ Bleeding ☐ Discharge ☐ Itching/Rash

What are your current wellness goals?			
Energy - Vitality	*Body Composition*	*Stress, Mental, Emotional*	*Life Enrichment*
☐ Feel more vital ☐ Increase energy ☐ Increase endurance ☐ Be less tired after lunch ☐ Sleep better ☐ Be free of pain ☐ Reduce colds and flu ☐ Get rid of allergies ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc. ☐ Stop using laxatives and stool softeners ☐ Improve sex drive	☐ Loose weight ☐ Burn more body fat ☐ Increase physical strength ☐ Improve muscle tone ☐ Increase flexibility	☐ Learn how to reduce stress ☐ Think more clearly and be more focused ☐ Improve memory ☐ Decrease depression ☐ Decrease moodiness ☐ Decrease indecisiveness ☐ Increase motivation	☐ Reduce risk of degenerative disease ☐ Decelerate the aging process ☐ Maintain wellness long term ☐ Transforming into a wellness focused lifestyle

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
When was the last time you had a cold or the flu?		
List any medical problems or illnesses that your Doctor has diagnosed		

Surgeries		
Year	Reason	Hospital
Other hospitalizations or laboratory procedures performed (ie: stool analysis, blood or urine chemistry, hair analysis, cortisol tests)		
Year	Reason & Outcome	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength & Reason for Taking	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.	
Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)
	What type of exercise do you prefer?

Diet	Are you dieting? Yes/No If Yes, what does dieting mean to you?				
	If yes, are you on a physician prescribed medical diet? Yes/No				
	# of meals you eat in an average day? What does a typical day look like for you with your meals? Breakfast: Lunch: Dinner:				
	How often do you snack between meals? What do you typically eat for snacks during the day?				
	What type of beverages do you typically drink during the day?				
	Do you have any food allergies? Yes/No If Yes, please list:				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Body	Do you consider yourself:	☐ Underweight	☐ Overweight	☐ Just Right	
	Have you had an unintentional weight loss or gain in the last three months? Yes/No If yes, explain:				
	Your weight today:				
Stress	On a scale of 1-10 (1 being the lowest), what level of stress are you currently experiencing?				
	Please identify the major sources of stress:				
	Is your job associated with potentially harmful chemicals or health and/or life threatening activities? Yes/No If yes, please explain:				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ No

Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	