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HEALTH HISTORY QUESTIONNAIRE

This is a confidential questionnaire that is helpful in determining the best treatment plan for you. Feel free to ask questions.

Name	Cell phone	Date
Street City State Zip		Gender: M / F Age:
	Home phone	Date of Birth
		Height Weight
Emergency contact (name and number)	Email	Physician (name and number)

Current Health Condition

What is the main problem(s) you would like to address?_____

_____

Have you been given a diagnosis by a physician? _____

What other concurrent therapies have you sought? _____

What other health problems do you now have? _____

Lab results (please list lab results that are out of range, i.e. cholesterol, glucose, thyroid...)_____

Present Medical History

Current Medications (include vitamins, over the counter drugs, herbs):_____

_____

Allergies (drug, chemical, food):_____

Occupational stresses (chemical, physical, psychological):_____

Exercise (types and frequency):_____

Daily diet (include cravings):_____

Habits (include amount and frequency): Tobacco Coffee Tea Soda Alcohol Drugs Other _____

_____

Past Medical History

Hospitalizations (Med/Psych):_____

Significant Illnesses:_____

Surgeries:_____

Significant Trauma (auto, falls, etc):_____

OB/GYN: Age of menarche_____ Age of menopause_____ # Pregnancies_____ # Live births_____
Duration of flow_____ Date of last PAP_____ # Abortions_____ # Miscarriages_____
Length of cycle_____ Date of last period_____ Are you currently pregnant? Y N
>Any abnormal test results (PAP, mammogram, bone density scan, GYN exam)?_____
>Have you been diagnosed with: □ Fibroids □ Fibrocystic breasts □ Endometriosis □ Ovarian cysts □ PCOS □ PID
<Color of menstrual flow: □ bright red □ red □ brick red □ dark red □ brown <Are there clots? Y N
<How many pads/tampons do you use per day?_____
<Do you get symptoms related to your period? □ irritability □ sadness □ bloating □ swollen breasts □ cramping
□ nausea □ diarrhea □ constipation □ disturbed sleep □ changes in appetite □ night sweats □ changes in libido
□ headaches □ vaginal dryness □ hot flashes □ discharge □ other _____
<What is the location of your pain/cramping?_____
<What is the nature of your pain? □ cramping □ stabbing □ dull □ burning □ bearing down □ aching □ bloating

Family Medical History

□ Diabetes □ Cancer □ High Blood Pressure □ Heart Disease □ Stroke □ Seizures □ Asthma □ Allergies
□ Alcoholism/Drug Abuse □ Hepatitis □ Tuberculosis □ Emotional Disorders □ Infectious Diseases
□ Other _____

Please indicate how you feel about the following areas of your life:

	Great	Good	Fair	Poor	Bad	Comments
<Significant other	□	□	□	□	□	_____
<Family	□	□	□	□	□	_____
<Diet	□	□	□	□	□	_____
<Sex	□	□	□	□	□	_____
<Self	□	□	□	□	□	_____
<Work	□	□	□	□	□	_____
<Exercise	□	□	□	□	□	_____
<Spirituality	□	□	□	□	□	_____

Please mark an "X" for conditions you have, and a "P" for conditions you had in the past.

__ AIDS
__ Alcoholism
__ Anemia
__ Anorexia
__ Arthritis
__ Asthma
__ Bleeding disorders
__ Bronchitis
__ Bulimia
__ Cancer
__ Cataracts
__ Chemical dependency
__ Chicken Pox
__ Chlamydia
__ Colitis
__ COPD
__ Diabetes
__ Diverticulitis
__ Emphysema
__ Epilepsy
__ Gall Stones
__ GERD
__ Glaucoma
__ Goiter
__ Gonorrhea
__ Gout
__ Heart disease
__ Hepatitis
__ Herpes
__ High Blood Pressure
__ High Cholesterol
__ HIV positive
__ HPV
__ Kidney Disease
__ Kidney Stones
__ Liver Disease
__ Low Blood Pressure
__ Measles
__ Migraines
__ Mononucleosis
__ Multiple Sclerosis
__ Mumps
__ Pacemaker
__ Pneumonia
__ Polio
__ Prostate problem
__ Psychiatric problem
__ Rheumatic Fever
__ Sciatica
__ Seizure
__ Stroke
__ Syphilis
__ Thyroid problems
__ Tuberculosis
__ Ulcers
__ UTI
__ Venereal Disease
__ Yeast infection
__ Other:

Please mark an "X" for symptoms you have, and a "P" for symptoms you had in the past.

General
__ chills
__ fever
__ body aches
__ poor appetite
__ excessive appetite
__ insomnia/difficulty sleeping
__ fatigue
__ poor circulation
__ cold hands/feet
__ excessive thirst
__ bodily heaviness
__ vertigo/dizziness
__ weight loss/gain
__ night sweats
__ spontaneous sweating
__ bruise easily
__ edema
__ allergies
__ tendency to catch colds
__ intolerant to weather change
__ tendency to faint easily
__ recent use of antibiotics
__ other_____

Head, Eyes, Ears, Nose, Throat
__ headaches
__ concussions
__ eyes pain
__ red/itchy eyes
__ spots in the vision
__ poor/blurred vision
__ night blindness
__ impaired hearing
__ ringing in the ears
__ nasal problems
__ nasal congestion
__ sinus problems
__ impaired sense of smell
__ hay fever
__ TMJ syndrome
__ facial pain
__ bleeding gums
__ sores on lips/tongue
__ dry mouth
__ recurrent sore throat
__ hoarse voice
__ lumps in throat
__ other_____

Respiratory
__ difficulty breathing
__ shortness of breath
__ cough
  wet or dry?
  color of phlegm
  thick or thin?
  with blood?
__ wheezing
__ bronchitis
__ other_____

Cardiovascular
__ chest pain
__ tachycardia
__ difficulty breathing
__ palpitations
__ irregular heart beat
__ phlebitis
__ other_____

Gastrointestinal
__ nausea
__ vomiting
__ stomach/abdominal pain
__ acid regurgitation
__ heart burn
__ belching
__ bad breath
__ bloating
__ gas
__ difficult digesting oily food
__ food retention in stomach
__ diarrhea/loose stool
__ constipation
__ bloody stool
__ black, tarry stool
__ light colored stool
__ mucus in stool
__ hemorrhoids
__ laxative use
__ intestinal pain/cramping
__ rectal pain
__ other_____

Musculoskeletal
__ spasm/twitching of muscles

Pain, weakness, numbness in:
__ hands __ wrist __elbow
__ shoulder __ neck __ back
__ hips __ knees __ legs
__ sciatic __ ankle __feet
__ other:

Skin, Hair and Nails
__ rashes
__ fungal infections
__ eczema
__ dermatitis
__ ulcerations
__ hives
__ acne
__ psoriasis
__ hair loss
__ change in moles
__ jaundice
__ soft, brittle nails
__ other_____

Neuropsychological
__ seizures
__ numbness
__ poor memory
__ easily stressed
__ irritable
__ easily angered/agitated
__ anxiety
__ depression
__ suicide thought/attempts
__ obsessive behavior
__ nightmares
__ mentally restless
__ laughing for no reason
__ claustrophobia
__ difficulty making decisions
__ other_____

Genital-urinary
__ frequent urination
__ urgent urination
__ painful urination
__ blood in urine
__ incomplete urination
__ pain or cold in genital area
__ kidney stone
__ bed wetting
__ increased libido
__ decreased libido
__ impotence
__ other_____

Gynecology
__ irregular periods
__ painful periods
__ PMS
__ vaginal discharge
__ vaginal sores
__ other_____

Additional Comments:_____

_____

_____

Signature_____ Date_____