Health History Questionnaire

Name (First & Last)	Referred By	Email
Day Phone	Evening Phone	Cell Phone
Street/PO Box	City	State & Zip Code
Date of Birth	Age	Sex
Height	Weight	Marital Status
Occupation	Emergency Contact Name & Phone Number	

Main Complaint	
How long ago did this problem begin?	Did this problem change over time (better, worse, same)?
Have you been given a diagnosis?	What other kinds of treatments have you tried?
Does anything make it better (heat, cold, humidity, dryness, pressure, season, movement, food, etc.)?	
Does anything make it worse (heat, cold, humidity, dryness, pressure, season, movement, food, stress, etc.)?	
How does this problem interfere with daily activities (work, sleep, diet, exercise, etc.)?	

Secondary Complaint	
How long ago did this problem begin?	Did this problem change over time (better, worse, same)?
Have you been given a diagnosis?	What other kinds of treatments have you tried?
Does anything make it better (heat, cold, humidity, dryness, pressure, season, movement, foods, etc.)?	
Does anything make it worse (heat, cold, humidity, dryness, pressure, season, movement, food, stress, etc.)?	
How does this problem interfere with daily activities (work, sleep, diet, exercise, etc.)?	

Past Medical History

Please circle all that apply

Asthma | Cancer | Diabetes | High/Low Blood Pressure | Heart Disease

Thyroid | Seizure | Stroke | Other (specify):

Surgeries or Trauma (auto accidents, falls, etc.) including dates

Infectious Diseases (HIV, hepatitis, etc.)

Allergies (food, drug, chemical, latex, environmental)

Diet and Exercise

Please describe your average daily diet

Morning:

Lunch:

Dinner:

Snacks:

Do you smoke? If yes, how much?

How many cups of caffeinated beverages do you drink per day (coffee, tea, cola)?	How many cups of water do you drink per day?	How many glasses of alcohol do you drink per day?

Exercise program

Current Medications/Herbs/Vitamins/Supplements

Name	*Start Date*	*Dosage/Frequency*	*Reason for taking*

Please check the box if you had any of the following in the past 3 months.

General

- ☐ Fevers
- ☐ Chills
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Bleed or bruise easily
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Vivid dreams
- ☐ Sudden energy drop
- ☐ Fatigue
- ☐ Fatigue after eating
- ☐ Weight loss or gain
- ☐ Strong thirst (hot or cold)
- ☐ Peculiar taste or smell
- ☐ Cravings

Skin & Hair

- ☐ Rashes
- ☐ Hives
- ☐ Eczema
- ☐ Ulcerations
- ☐ Pimples
- ☐ Recent moles
- ☐ Dry or oily skin
- ☐ Itching
- ☐ Dandruff
- ☐ Dry hair
- ☐ Hair loss
- ☐ Other skin or hair problem

Head, Ears, Eyes, Nose, Throat

- ☐ Headaches
- ☐ Migraines
- ☐ Concussion
- ☐ Poor memory
- ☐ Facial pain
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Glasses or contact lenses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Eye pain
- ☐ Eye redness
- ☐ Eye itching
- ☐ Eye dryness
- ☐ Spots in front of eyes
- ☐ Night blindness
- ☐ Sinus problems
- ☐ Congested nose
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Sores on lips or tongue
- ☐ Teeth problems
- ☐ Jaw problems
- ☐ Grind teeth
- ☐ Other head problem

Cardiovascular

- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Heaviness in chest
- ☐ Irregular heart beat
- ☐ Heart palpitations
- ☐ Difficulty breathing
- ☐ Fainting
- ☐ Cold hands
- ☐ Cold feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Poor circulation
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Other heart problem
- ☐ Other blood vessel problem
- ☐ Taking blood thinner (anticoagulant)

Respiratory

- ☐ Asthma
- ☐ Dry cough
- ☐ Coughing blood
- ☐ Coughing phlegm
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Difficulty inhaling
- ☐ Difficulty exhaling
- ☐ Other lung/breathing problem

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Belching
- ☐ Indigestion
- ☐ Heartburn
- ☐ Abdominal pain or cramps
- ☐ Abdominal bloating
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Gas
- ☐ Constipation
- ☐ Loose stools or diarrhea
- ☐ Hemorrhoids
- ☐ Rectal pain
- ☐ Blood in stools
- ☐ Chronic laxative use
- ☐ Other stomach problem
- ☐ Other intestinal problem

Genito-Urinary

□ Pain upon urination	□ Urgent urination	□ Impotency
□ Blood in urine	□ Unable to hold urine	□ Sores on genitals
□ Cloudy urine	□ Wake up to urinate	□ Other urinary problem
□ Frequent urination	□ Kidney stones	□ Other genital problem

Reproductive & Gynecological

Are you pregnant?		Is it possible that you are pregnant?	
# of pregnancies	# of live births	# of miscarriages	# of abortions
Age of first menses	Age of menopause	# of days of flow	# of days between menses
Last menstrual period (1st day of period)	Last PAP Date	Birth control method	Other problem

□ Regular period	□ Light flow	□ Blood clots
□ Irregular period	□ Heavy flow	□ PMS symptoms
□ Painful period	□ Spotting between periods	□ Vaginal discharge

Psychological

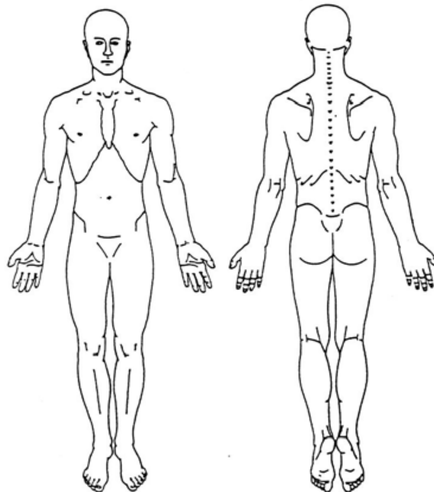
Have you ever been treated for emotional problems?	Have you ever considered or attempted suicide?

□ Anger	□ Stress	□ Grief
□ Irritability	□ Depression	□ Sadness
□ Bad temper	□ Obsessing	□ Fear
□ Anxiety	□ Worrying	□ Other emotion

Musculoskeletal

□ Joint problem	□ Muscle pain	□ Numbness
□ Bone problem	□ Muscle weakness	□ Other musculoskeletal problem

Please mark any problem area(s) below with an X.



Please note any additional problems below.