

Renata Teytelbaum MD, AMMGC

585 Main Street, Suite 101
Dunedin, Florida 34698

P 727.734.6777
F 727.734.6440

Health History Questionnaire

All material in this questionnaire is strictly confidential and will become part of your medical record.

Today's Date: _____

Last Name: _____

First Name: _____ Middle Name: _____

DOB: ____ / ____ / ____ Age: ____ Gender: ☐ Female ☐ Male ☐ Prefer not to state

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Preferred Daytime Contact Phone: ☐ Home ☐ Cell ☐ Work

Race/Ethnicity: _____

Relationship status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Occupation: _____ Employer: _____

PCP Name & Phone Number: _____

Names of Specialists (if any): _____

Date of last physical: _____

Referred by: _____

Main reason for visit: _____

Past & Present Medical Conditions

	Yes	No	Date
Headaches			
Stroke			
Seizures			
Pneumonia			
Diabetes (Type 1 or Type 2)			
Thyroid Disease (Low or High)			
Glaucoma			
Macular Degeneration			
Hearing Loss			
High Blood Pressure			
Blood Clots			
<input type="checkbox"/> Pulm Emboli (lung clots)			
<input type="checkbox"/> DVT (leg clots)			
Heart Burn, Reflux			
Stomach Ulcers			
Heart Disease			
<input type="checkbox"/> Coronary Disease			
<input type="checkbox"/> MI/heart attacks			
<input type="checkbox"/> Congestive Heart Failure			
<input type="checkbox"/> Atrial Fibrillation			
<input type="checkbox"/> Angina			
<input type="checkbox"/> Valve Disorder			
High Cholesterol			
Gastrointestinal Bleeding			
Hepatitis (A, B, or C)			
HIV / AIDS			
Chronic Wounds			
Cancer (specify type)			
Urinary Tract Infections			
Incontinence			
Kidney Stones			
COPD (Emphysema, Bronchitis)			
Asthma			
Depression			
Bipolar Disorder			
Anxiety			
Fibromyalgia			
Chronic Fatigue Syndrome			
Arthritis			
Gout			
Osteoporosis			
Prostate Disease			
Breast Disease			
Erectile Dysfunction			
Other:			

Have you had ☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Polio ☐ Rheumatic Fever

Past Surgeries & Hospitalizations (indicate date if known)

☐ None _____

☐ Cataracts _____

☐ LASIK _____

☐ Tonsillectomy _____

☐ Thyroidectomy _____

☐ Adenoidectomy _____

☐ Coronary Bypass _____

☐ Cardiac Stents _____

☐ Pacemaker _____

☐ Heart Valve _____

☐ Gall Bladder _____

☐ Appendectomy _____

☐ Bowel/Stomach Resection _____

☐ Hemorrhoidectomy _____

☐ Bariatric Surgery _____

☐ Hysterectomy _____

☐ Endoscopy _____

☐ Colonoscopy _____

☐ Hernia _____

☐ Spinal Surgery _____

☐ Tubal Ligation _____

☐ Bladder Surgery _____

☐ Prostate Surgery/resection _____

☐ C-section _____

☐ Orthopedic/joints _____

☐ Other _____

Prescribed pharmaceutical and/or nutraceutical medication & dosages if known:

OTC drugs/vitamins/supplements/herbs & dosages if known:

Known drug allergies/sensitivities: _____

Known food allergies/sensitivities: _____

Known environmental allergies: _____

Family History

	Mother	Father	Siblings	Grandparents
Heart Disease				
Diabetes				
Bleeding problem				
High blood pressure				
Cancer				
TB				
Stroke				
Other				

Is your mother alive? ☐ Yes ☐ No, cause of death: _____

Is your father alive? ☐ Yes ☐ No, cause of death: _____

Lifestyle Questions

Relationship status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Other

Do you have children? ☐ No ☐ Yes, I have ____ children and they are aged: _____

Are you trying to lose weight? ☐ No ☐ Yes If yes, how many pounds? _____

Within the past 5 years, your: Highest Weight: _____ Lowest weight: _____

Are you following a diet? ☐ No ☐ Yes

If yes, type: ☐ Doctor Prescribed ☐ Atkins ☐ Mediterranean ☐ South Beach ☐ Raw Food

☐ Vegan ☐ The Zone ☐ Vegetarian ☐ Weight Watchers ☐ NutriSystem ☐ Jenny Craig

☐ Macrobiotic ☐ Cookie ☐ Glycemic Index ☐ Other: _____

Do you exercise? ☐ No ☐ Yes If yes, what type of exercise? _____

How many times per week? _____ How many minutes per day? _____

Have you ever been a member at a gym? _____ Worked with personal trainer? _____

Do you drink alcohol? ☐ No ☐ Yes What is the frequency? _____

Are you dependent on alcohol? _____ If so, for how many months/years? _____

What is/are your preferred alcoholic beverage(s)? _____

Do you currently abuse recreational or prescription drugs? ☐ No ☐ Yes

For how long and what types? _____

Do you smoke? ☐ No, never ☐ I used to for this many years: _____ Packs per day: _____

☐ Yes, currently. Number of packs daily: _____ Since age: _____

How many hours of sleep do you get? _____ Is it refreshing/restorative? _____

Do you take naps during the day? ☐ No ☐ Yes

Do you wake up in the middle of the night? ☐ No ☐ Yes

How many times and why? _____

Have you ever been exposed to chemicals? _____

Do you drink coffee? ☐ No ☐ Yes _____ cups daily and type(s) _____

Do you use sweeteners? ☐ No ☐ Yes, I use this type: _____

How many glasses of water do you drink daily? _____ Type of water? _____

What types of cravings do you have? ☐ Sweet ☐ Salty ☐ Fatty ☐ Carbs

What are your main sources of protein? _____

How many fruits and vegetables do you eat daily? _____ Types? _____

How often do you eat fast food? _____ How many meals do you eat daily? _____

Do you eat breakfast? ☐ No ☐ Yes, I eat: _____

Describe your lunch: _____

Describe your dinner: _____

Do you snack between meals? ☐ No ☐ Yes, I snack on: _____

Have you ever seen a therapist or a life coach? _____

At what age did you feel your best? Or do you think it is yet to come? _____

What do you enjoy most in life? _____

What are you most scared of in life? _____

What are your hobbies? _____

Are you religious or spiritual? _____

Do you enjoy your job? _____ Do you feel fulfilled in life? _____

What are your life stressors? _____

Best describe your sexual orientation: _____

Have you ever been abused (physically, emotionally, sexually)? _____

If you are in a relationship, is it healthy? _____ Do you have emotional support? _____

Who is in your household? _____

Do you have pets? _____

How would you describe your personality? _____

What goals do you want to achieve in life? _____

REVIEW OF SYSTEMS

GENERAL	YES	NO	GASTROINTESTINAL	YES	NO
Recent fever			Loss of appetite		
Anemia			Indigestion		
Night sweats			Heartburn		
Swollen glands			Nausea		
Undue tiredness			Vomiting		
Unexplained weight loss			Vomiting blood		
Weight gain			Diarrhea		
HEAD			Constipation		
Tension or frequent headaches			Blood in stool		
Fainting spells			Pale stools		
Hair change			Abdominal pain <input type="checkbox"/> Upper <input type="checkbox"/> Lower		
Convulsions			Gall bladder problems		
EYES			Food intolerance		
Glasses			What foods?		
Discharge					
Pain			NOSE		
Blurred vision			Drainage		
Glaucoma			Bleeding		
Cataracts			Snoring		
NECK			MOUTH		
Goiter			Dentures		
Thyroid trouble			Sore throat		
Stiffness			Swallowing difficulty		
BREASTS			Hoarseness		
Lumps			EARS		
Discharge			Hearing loss		
HEART			ringing		
Chest pain or pressure on exertion			Discharge		
Shortness of breath:			Pain		
On exertion			CHEST		
At rest			Cough		
Use more than one pillow to sleep			Phlegm <input type="checkbox"/> Colored <input type="checkbox"/> Clear		
Swelling of ankles			Pain in any part of chest/upper back		
Heart palpitations, pounding, or skipping			Blood in mucus		
High blood pressure			Wheezing		
Heart murmur			Unable to lay flat		
SKIN			GENITO-URINARY		
Rashes			Pain or burning on passing water		
Lumps			Frequency		
Easy bruising			Blood in urine		
Eczema			Trouble starting urine		
Psoriasis			Up at night to urinate		
EXTREMITIES			How many times?		
Joint pain or swelling			Leakage of urine		
Varicose veins			Pain or trouble with sexual intercourse		
Paralysis			NERVOUS SYSTEM		
Weakness			Depression		
Numbness			Nervousness		
Pain on walking			Trouble sleeping		
Back trouble			Excessive worry		
			Suicidal thoughts		