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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 □ Pulm Emobli (lung clots) □ DVT (leg clots)			
Heart Burn, Reflux			
Stomach Ulcers			
Heart Disease □ Coronary Disease □ MI/heart attacks □ Congestive Heart Failure □ Atrial Fibrillation □ Angina □ 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

Please indicate family member, when selecting a condition.

□ Heart Disease _____ □ Cancer _____

□ Diabetes _____ □ TB _____

□ Bleeding problem _____ □ Stroke _____

□ High blood pressure _____

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

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

Lifestyle Questions

Are you: □ Single □ Married □ in a 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
Recent fever		
Anemia		
Night sweats		
Swollen glands		
Undue tiredness		
Unexplained weight loss		
Weight gain		
HEAD		
Tension or frequent headaches		
Fainting spells		
Hair change		
Convulsions		
EYES		
Glasses		
Discharge		
Pain		
Blurred vision		
Glaucoma		
Cataracts		
NECK		
Goiter		
Thyroid trouble		
Stiffness		
BREASTS		
Lumps		
Discharge		
HEART		
Chest pain or pressure on exertion		
Shortness of breath:		
On exertion		
At rest		
Use more than one pillow to sleep		
Swelling of ankles		
Heart palpitations, pounding, or skipping		
High blood pressure		
Heart murmur		
SKIN		
Rashes		
Lumps		
Easy bruising		
Eczema		
Psoriasis		
EXTREMITIES		
Joint pain or swelling		
Varicose veins		
Paralysis		
Weakness		
Numbness		
Pain on walking		
Back trouble		

GASTROINTESTINAL	YES	NO
Loss of appetite		
Indigestion		
Heartburn		
Nausea		
Vomiting		
Vomiting blood		
Diarrhea		
Constipation		
Blood in stool		
Pale stools		
Abdominal pain □ Upper □ Lower		
Gall bladder problems		
Food intolerance		
What foods?		
NOSE		
Drainage		
Bleeding		
Snoring		
MOUTH		
Dentures		
Sore throat		
Swallowing difficulty		
Hoarseness		
EARS		
Hearing loss		
Ringing		
Discharge		
Pain		
CHEST		
Cough		
Phlegm □ Colored □ Clear		
Pain in any part of chest/upper back		
Blood in mucus		
Wheezing		
Unable to lay flat		
GENITO-URINARY		
Pain or burning on passing water		
Frequency		
Blood in urine		
Trouble starting urine		
Up at night to urinate		
How many times?		
Leakage of urine		
Pain or trouble with sexual intercourse		
NERVOUS SYSTEM		
Depression		
Nervousness		
Trouble sleeping		
Excessive worry		
Suicidal thoughts		