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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 and Family History

	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

Is your mother: □ Alive, Age & current medical/psych problems: _____

□ Deceased, Age at death and cause: _____

Is your father: □ Alive, Age & current medical/psych problems: _____

□ Deceased, Age at death and cause: _____

Do you have siblings? □ No □ Yes

Brother(s) (full and half), age(s), medical/psych problems: _____

_____

Sister(s) (full and half), age(s), medical/psych problems: _____

_____

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: _____

Lifestyle Questions

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? _____

_____

_____