

Date \_\_\_\_\_

Name \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender M/F

Place of Birth \_\_\_\_\_ Referred By \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Approximate Hours Per Week Worked \_\_\_\_\_ Retired? \_\_\_\_\_

Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Single \_\_\_ Partnership \_\_\_

Live With: Spouse \_\_\_ Partner \_\_\_ Parents \_\_\_ Children \_\_\_ Friends \_\_\_ Alone \_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

HEALTH HISTORY QUESTIONNAIRE

What Are Your Most Important Health Problems? List in Order of Importance.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Are You Currently Receiving Healthcare at Another Facility?

If Yes, Name of Practitioner? \_\_\_\_\_

List Any Hospitalizations or Surgeries You've Had w/ Dates: \_\_\_\_\_

\_\_\_\_\_

List Any X-Rays, CAT Scans or MRI's You've Had w/ Dates: \_\_\_\_\_

\_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight One Year Ago \_\_\_\_\_ Max Weight \_\_\_\_\_

When is Your Energy Level the Best \_\_\_\_\_ Worst \_\_\_\_\_

FAMILY HISTORY: Are You Adopted? \_\_\_\_\_

List All Significant Diseases (i.e.: cancer, diabetes) of Immediate Family Members:

Father \_\_\_\_\_ Mother \_\_\_\_\_

Siblings \_\_\_\_\_ Aunts / Uncles \_\_\_\_\_

Grandfather \_\_\_\_\_ Grandmother \_\_\_\_\_

MEDICATIONS: Are You Currently Taking Any of the Following (Circle) :

Laxatives / Pain Relievers / Appetite Suppressant / Antacids / Antibiotics / Sleep Aids  
/ Thyroid Meds. / Cortisone / Tranquilizers /

List Any Prescriptions, Over the Counter, Vitamins or Supplements You're Taking.

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

SYMPTOM REVIEW

Y= Current Problem \* N= Never Had \* P= Had Before, Not Currently

EMOTIONAL

Mood Swings	Y N P	Depression	Y N P
Considered/Attempted Suicide	Y N P	Anxiety or Nervousness	Y N P

ENDOCRINE

Hypothyroid	Y N P	Heat/Cold Intolerance	Y N P
Hypoglycemia	Y N P	Diabetes	Y N P
Excessive thirst	Y N P	Excessive hunger	Y N P
Fatigue	Y N P	Seasonal depression	Y N P

IMMUNE

Vaccinations	Y N P	Reactions to vaccinations	Y N P
Chronic Fatigue Syndrome	Y N P	Chronic Infections	Y N P
Chronically swollen glands	Y N P	Slow wound healing	Y N P

NEUROLOGIC

Seizures	Y N P	Paralysis	Y N P
Muscle weakness	Y N P	Numbness/tingling	Y N P
Loss of memory	Y N P	Dizziness	Y N P
Vertigo	Y N P	Loss of balance	Y N P

SKIN

Rashes	Y N P	Eczema, Hives	Y N P
Acne, Boils	Y N P	Itching	Y N P
Color change	Y N P	Perpetual hair loss	Y N P
Lumps	Y N P	Night sweats	Y N P

HEAD

Headaches	Y N P	Head Injury	Y N P
Migraine	Y N P	Jaw /TMJ	Y N P

EYES

Spots in eyes	Y N P	Cataracts	Y N P
Impaired vision	Y N P	Glaucoma	Y N P
Blurriness	Y N P	Eye pain, strain	Y N P
Color blindness	Y N P	Tearing or dryness	Y N P

EARS

Impaired hearing	Y N P	Ringling	Y N P
Earaches	Y N P	Dizziness	Y N P

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NOSE AND SINUSES

Frequent colds	Y N P	Nose bleeds	Y N P
Stuffiness	Y N P	Hay fever	Y N P
Sinus problems	Y N P	Loss of smell	Y N P

MOUTH AND THROAT

Frequent sore throat	Y N P	Sore tongue, lips	Y N P
Teeth grinding	Y N P	Hoarseness	Y N P
Gum problems	Y N P	Jaw clicks	Y N P

NECK

Lumps	Y N P	Swollen glands	Y N P
Goiter	Y N P	Pain or stiffness	Y N P

RESPIRATORY

Cough	Y N P	Sputum	Y N P
Spitting up blood	Y N P	Wheezing	Y N P
Asthma	Y N P	Bronchitis	Y N P
Pneumonia	Y N P	Pleurisy	Y N P
Emphysema	Y N P	Difficulty breathing	Y N P
Pain on breathing	Y N P	Shortness of breath	Y N P
Short of breath @ night	Y N P	" " " lying down	Y N P
Tuberculosis	Y N P		

CARDIOVASCULAR

Heart disease	Y N P	Angina	Y N P
High/low blood pressure	Y N P	Murmurs	Y N P
Blood clots	Y N P	Fainting	Y N P
Rheumatic Fever	Y N P	Palpitations/fluttering	Y N P
Swelling in ankles	Y N P	Chest pain	Y N P

GASTROINTESTINAL

Trouble swallowing	Y N P	Heartburn	Y N P
Change in thirst	Y N P	Hemorrhoids	Y N P
Nausea	Y N P	Vomiting	Y N P
Vomiting blood	Y N P	Bowel Movements: how often _____	
Blood in stool	Y N P	Is this a change _____	
Pain or cramps	Y N P	Constipation	Y N P
Belching	Y N P	Diarrhea	Y N P
Passing gas	Y N P	Gall bladder disease	Y N P

URINARY

Pain on urination	Y N P	Increased frequency	Y N P
Frequency at night	Y N P	Inability to hold urine	Y N P
Frequent infections	Y N P	Kidney stones	Y N P

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MALE REPRODUCTION

Hernias	Y N P	Testicular masses	Y N P
Testicular pain	Y N P	Prostate disease	Y N P
Venereal disease	Y N P	Syphilis	Y N P
Chlamydia	Y N P	Gonorrhea	Y N P
Impotence	Y N P	Herpes	Y N P

FEMALE REPRODUCTION

Age of first menses	_____	Are cycles regular	_____
Length of cycles	_____ days	Bleeding between cycles	Y N P
Duration of menses	_____ days	Pain with intercourse	Y N P
Painful menses	Y N P	Clotting	Y N P
Heavy or excessive flow	Y N P	Discharge	Y N P
PMS	Y N P	Birth control	Y N P
If yes, what are your symptoms		Type of birth control	_____
		Number of pregnancies	_____
Endometriosis	Y N P	Number of live births	_____
Ovarian cysts	Y N P	Number of miscarriages	_____
Difficulty conceiving	Y N P	Number of abortions	_____
Cervical dysplasia	Y N P	Menopausal symptoms	_____
Sexual difficulties	Y N P	Abnormal PAP	Y N P
Gonorrhea	Y N P	Chlamydia	Y N P
Herpes	Y N P	Condyloma	Y N P
Are you sexually active	Y N	Syphilis	Y N P
Breast lumps	Y N P	Nipple discharge	Y N P

MUSCULOSKELETAL

Joint pain or stiffness	Y N P	Arthritis	Y N P
Broken bones	Y N P	Weakness	Y N P
Muscle spasms or cramps	Y N P	Sciatica	Y N P

BLOOD / PERIPHERAL VASCULAR

Easy bleeding or bruising	Y N P	Anemia	Y N P
Deep leg pain	Y N P	Cold hands/feet	Y N P
Varicose veins	Y N P		

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE