



Clinic use only: Dr: _____ SSN checked: Y N Leave message at: Cell Home Work

Date _____ Name you prefer to be called _____
 First Name _____ Middle _____ Last _____
 Date of Birth _____ Age _____ Sex ***(circle one):*** F M F to M M to F
 Address _____
 City _____ State _____ Zip Code _____
 Cell Phone (____) _____ Work Phone (____) _____
 Home Phone (____) _____ Other Phone (____) _____
 Best contact number? **Cell Work Home Other** Best number to leave a message? **C W H O**
 E-mail Address: _____ May we contact you by email? **Y N**

Occupation _____ Hours per week _____ Retired **Y N**
 Employer _____ Location _____
 SS#: _____ - _____ - _____ ***(Required if billing insurance or carrying a balance.)***

What is your relationship status? ***(Please circle one):***
 Single Married Significant Partner Separated Divorced Widowed

Do you live with: ***(Please circle all that apply):***
 Alone Spouse/Partner Child(ren) Parent(s) Relative(s) Friend(s) Roommate(s)

Emergency contact _____ Relationship _____
 Phone _____ or _____ Location (city, state) _____

I am willing to let my medical records be used anonymously for research purposes. **Y N**

HISTORY QUESTIONNAIRE

Holistic health care and preventive medicine are only possible when the physician has complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. ***Print all information; mark anything you don't understand with a question mark.***

When did you last receive medical/health care? _____

Where? _____

For what reason? _____

What are your most important health issues? List as many as you can in order of importance:

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

How did you hear about us? ***(Please check if applicable)***

Medical Referral _____ Friend _____ Who? _____ TV _____ Radio _____

Yellow Pages _____ Internet _____ Ads _____ Which one? _____ Other _____

Family History: Please check applicable conditions for each family member.

	Father	Mother	Brother	Sister	Child	Spouse/Partner
Age (if living, or at death)	_____	_____	_____	_____	_____	_____
(If deceased) Cause	_____	_____	_____	_____	_____	_____
Health: G=Good P=Poor	_____	_____	_____	_____	_____	_____
Cancer (Type?)	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Alzheimer's	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

For the following sections, please circle Y=Yes or N=No

Childhood Illnesses:

Scarlet fever **Y N** Diphtheria **Y N** Rheumatic Fever **Y N** German Measles **Y N**
Mumps **Y N** Measles **Y N** Other _____

Hospitalization and Surgery: Hospitalizations or surgeries you have had and when:

X-rays and Special Studies: X-rays, CAT scans, or MRI's you have had and when:

Electrocardiogram (EKG) **Y N** Electroencephalogram (EEG) **Y N**

Immunizations:

Polio **Y N** Tetanus Shot (not antitoxin) **Y N** Diphtheria **Y N**
Pertussis **Y N** Measles/Mumps/Rubella **Y N** Other _____

Allergies: Please list any foods, drugs, or other allergens, or check "none known": **None known** _____

Current Medications: Do you take or use any of the following?

Laxatives **Y N** Pain relievers **Y N** Antacids **Y N**
Cortisone **Y N** Hormones **Y N** Sleeping pills **Y N**
Tranquilizers **Y N** Thyroid medication **Y N** Antidepressants **Y N**

Please list prescription medications, over the counter medications, vitamins or other supplements you are taking: _____

For the following sections, please circle one of the following:

Y = a condition you have now. **P** = a condition you have had in the past. **N** = you've never had. Please mark an asterisk (*) by any areas you would like to clarify with the doctor.

General		Maximum weight	_____
Weight	_____	What year?	_____
Weight 1 yr ago	_____	Height	_____
		Fatigue	Y P N

Skin
 Rashes Y P N
 Eczema, hives Y P N
 Acne, boils Y P N
 Itching Y P N
 Color change Y P N
 Lumps Y P N
 Nights sweats Y P N

Head
 Headaches Y P N
 Head Injury Y P N

Eyes
 Impaired vision Y P N
 Glasses or contacts Y P N
 Eye pain Y P N
 Tearing or dryness Y P N
 Double vision Y P N
 Glaucoma Y P N
 Cataracts Y P N

Ears
 Impaired hearing Y P N
 Ringing Y P N
 Earache Y P N
 Dizziness Y P N

Nose and Sinuses
 Frequent colds Y P N
 Nose bleeds Y P N
 Stuffiness Y P N
 Hay fever Y P N
 Sinus problems Y P N

Mouth and Throat
 Frequent sore throat Y P N
 Sore tongue Y P N
 Gum problems Y P N
 Hoarseness Y P N
 Dental cavities Y P N

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

Respiratory
 Cough Y P N
 Sputum Y P N
 Spitting up blood Y P N
 Bronchitis Y P N
 Pleurisy Y P N
 Emphysema Y P N
 Wheezing Y P N
 Asthma Y P N
 Shortness of breath Y P N
 “ at night Y P N

“ on lying down Y P N
 “ on exertion Y P N
 Difficulty breathing Y P N
 Pain on breathing Y P N
 Pneumocystis Y P N
 Tuberculosis Y P N

Cardiovascular
 Heart disease Y P N
 Chest pain Y P N
 Angina Y P N
 Palpitations, fluttering Y P N
 High blood pressure Y P N
 Heart murmur Y P N
 Rheumatic fever Y P N
 Swelling in ankles Y P N

Gastrointestinal
 Nausea Y P N
 Vomiting Y P N
 Vomiting blood Y P N
 Bowel movements - how often? _____
 Is this a change? Y N
 Blood in stool Y P N
 Gallbladder disease Y P N
 Liver disease Y P N
 Jaundice (yellow skin) Y P N
 Change in thirst Y P N
 Change in appetite Y P N
 Trouble swallowing Y P N
 Belching/passing gas Y P N
 Heartburn Y P N
 Ulcer Y P N
 Hemorrhoids Y P N

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

Female Reproductive
 First day of last menstrual cycle _____
 Average number of days _____
 Length of cycle _____
 Bleeding between periods Y P N
 Are cycles regular? Y P N
 Pain during intercourse Y P N
 Painful menses Y P N
 Excessive flow Y P N
 Do you use birth control? Y P N
 What type? _____
 How long? _____
 Number of pregnancies _____
 Number of live births _____

Number of miscarriages _____
 Number of abortions _____
 Difficulty conceiving Y P N
 Menopausal symptoms Y P N
 Are you sexually active? Y P N
 Sexual difficulties Y P N
 Sexually transmitted infection Y P N
 Sexual Orientation: Heterosexual _____
 Bisexual _____
 Homosexual _____

Breasts

Do you do a monthly self exam? Y P N
 Lumps Y P N
 Pain or tenderness Y P N
 Nipple discharge Y P N

Male Reproductive

Hernias Y P N
 Testicular masses Y P N
 Testicular pain Y P N
 Are you sexually active? Y P N
 Sexual difficulties Y P N
 Prostate Disease Y P N
 Sexually Transmitted Infection Y P N
 Discharge or sores Y P N
 Sexual Orientation: Heterosexual _____
 Bisexual _____
 Homosexual _____

Musculoskeletal

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

Blood

Anemia Y P N
 Bleed or bruise easily Y P N

Peripheral Vascular

Thrombophlebitis Y P N
 Cold hands/feet Y P N
 Varicose veins Y P N

Neurologic

Fainting Y P N
 Seizures Y P N
 Paralysis Y P N
 Muscle Weakness Y P N
 Numbness or tingling Y P N
 Loss of memory Y P N

Emotional

Depression Y P N
 Mood Swings Y P N
 Anxiety or nervousness Y P N
 Tension Y P N

Endocrine

Hypothyroid Y P N
 Heat or cold intolerance Y P N
 Excessive thirst Y P N
 Excessive hunger Y P N
 Diabetes Y P N

Habits

What are your main interests and hobbies?

Do you exercise? Y P N

What forms? _____

How often? _____

How many meals do you eat daily? _____

Sleep well? Y P N

Awaken rested? Y P N

Average 6-8 hours sleep? Y P N

Take vacations? Y P N

Enjoy your work? Y P N

Spend time outside? Y P N

How many hours/day do you:

 Watch television? _____

 Read? _____

Do you use tobacco? Y P N

Use alcoholic beverages Y P N

Use recreational drug Y P N

Treated for alcoholism Y P N

Treated for drug abuse Y P N

Are there any other issues not mentioned that you would like to discuss? _____
