



Name _____ Date _____
 Age _____ Date of Birth _____ Female/Male _____
 Address _____
 City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Occupation _____ Hours per week _____ Retired _____
 Employer _____ Address _____
 SS# _____ (Required if billing insurance or carrying a balance.)

Please circle which phone number is BEST to contact you at.

Are you: Married __ Separated __ Divorced __ Widowed __ Single __ Significant Partner __
 Live with:
 Spouse _____ Partner _____ Relatives _____ Friends _____ Alone _____ Parents _____

Next of kin or other to reach in an emergency _____
 Relationship _____ Address _____
 Phone _____ or _____

I am willing to let my medical records be used anonymously for research purposes.
 Yes _____ No _____

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 and mark anything you don't understand with a question mark.

When and where did you last receive medical/health care? _____

For what reason? _____

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

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

How did you hear about us? Referral? _____ Who? _____
 _____ TV _____ Radio _____

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

E-mail Address: _____

Family History:

Check those applicable	Father	Mother	Brother	Sisters	Spouse	Child
Age (If living)	_____	_____	_____	_____	_____	_____
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	_____	_____	_____	_____	_____	_____
Age (at death)& cause	_____	_____	_____	_____	_____	_____

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

Childhood Illnesses:

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

Hospitalization and Surgery: What hospitalizations or surgeries have you 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
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Immunizations:

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

Allergies: Please list any foods, drugs, or other allergens:

Current Medications:

Do you take or use?

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: _____

Please circle one: **Y** = a condition you have now. **N** = never had. **P** = a condition you have had in the past

General

Weight _____
 Weight 1 yr ago _____
 Maximum weight _____
 When _____
 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
 “ 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
 Murmurs 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? _____
 Blood in stool Y P N
 Gallbladder disease Y P N
 Liver Disease Y P N
 Jaundice(yellowskin) 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

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
 Birth control? Y P N
 What type? _____
 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
 Venereal disease Y P N
 Sexual Orientation:
 Heterosexual _____
 Bisexual _____
 Homosexual _____

Breasts

Do you do 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
 Venereal Disease 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/cramps Y P N
 Weakness 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

Blood

Anemia Y P N
 Easy bleeding or bruising Y P N

Habits

What are your main interests and hobbies? _____

Do you exercise? Y N
 What forms? _____

How often? _____

Do you eat three meals daily Y N
 Sleep well Y N
 Awaken rested Y N
 Average 6-8 hours sleep Y N
 Take vacations Y N
 Enjoy your work Y N
 Spend time outside Y N
 Watch television Y N
 how many hours a day? _____

Read Y N
 how many hours a day? _____

Use tobacco Y P N
 Use alcoholic beverages Y P N
 Use recreational drug Y P N
 Treated for alcoholism Y N
 Treated for drug abuse Y N