

## Health History Questionnaire

Date: \_\_\_ / \_\_\_ / \_\_\_

<b>Patient's Name</b> (Last, First, M.I.)		<b>DOB</b> (mm/dd/yyyy)	<b>Sex</b> (M/F)	<b>Patient Status:</b> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
<b>Patient's Address</b> (No. Street)		<b>Relation to Insured</b>		<b>Employed</b> <input type="checkbox"/> <b>Student:</b> F-Time <input type="checkbox"/> P-Time <input type="checkbox"/>	
<b>Patient's Address</b> (No. Street)		<b>Relation to Insured</b>		<b>Patient's Employer</b>	
<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Phone</b> (10 digit)		<b>Patient's SSN:</b>
<b>Insured's Name</b> (Last, First, M.I.)		<b>DOB</b> (mm/dd/yyyy)	<b>Sex</b> (M/F)	<b>Insured's SSN:</b>	
<b>Insured's Address</b> (No. Street)		<b>Phone</b> (10 digit)		<b>Insured's Employer</b>	
<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Insured's Claim Nbr. or ID Nbr.</b>		<b>Group ID Number</b>
<b>Insurance Company</b>			<b>Plan Name or Program</b>		
<b>Billing Address</b>			<b>Referral Nbr.</b>		
<b>Onset/Injury Date</b>	<b>Similar Condition (Y/N)</b>	<b>Work related (Y/N)</b>	<b>Auto Accident (Y/N)</b>	<b>U.S. State</b>	<b>Other Acc. (Y/N)</b>

What is your main complaint today? \_\_\_\_\_

When did this problem begin? (Please be specific) \_\_\_\_\_

What do you think caused it? Is the cause still present? \_\_\_\_\_

What treatments have you tried already? What were the results? \_\_\_\_\_

Have you been given a diagnosis for this problem? If so, what? \_\_\_\_\_

To what extent does this problem interfere with your daily activities? (work, sleep, eating, sex...) \_\_\_\_\_

How severe is your problem right now? (Please mark the scale below)

No problem	Moderate	Worst Imaginable
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What's the most severe level you have endured within the last week? (Please mark the scale below)

No problem	Moderate	Worst Imaginable
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Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Past Medical History (please indicate by date(s):

Cancer _____	High Blood Pressure _____	Rheumatic Fever _____	Venereal Disease _____
Diabetes _____	Heart Disease _____	Seizures _____	Asthma _____
Hepatitis _____	Stroke _____	Thyroid Disease _____	Pacemaker _____
Other: _____			

Surgeries (type and date): \_\_\_\_\_

Significant Trauma (auto accidents, falls, etc.): \_\_\_\_\_

Significant Dental Work (type and date): \_\_\_\_\_

Birth History (prolonged labor, forceps delivery, caesarian section, other): \_\_\_\_\_

Allergies (drugs, chemicals, foods, animals): \_\_\_\_\_

### Family Medical History

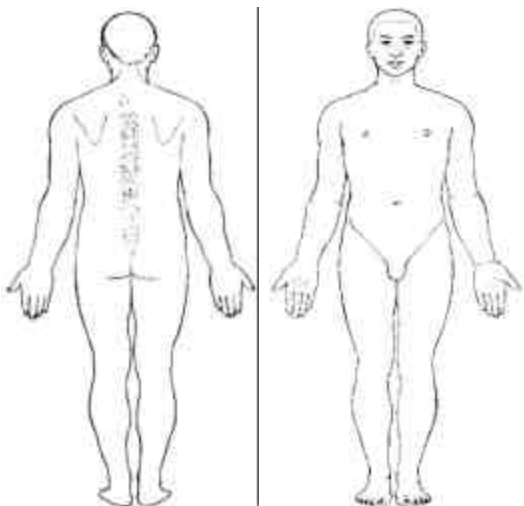
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer:	<input type="checkbox"/> Allergies:
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures	_____	_____
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Asthma	_____	_____
<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes	_____	_____

Occupational Stress (chemical, physical, psychological, etc.): \_\_\_\_\_

Do you exercise regularly? Y or N Please describe: \_\_\_\_\_

Comments (please list any other problems you would like to discuss): \_\_\_\_\_

### Indicate Painful or Distressed Areas



### What are Your Treatment Goals?

- Temporary relief of symptoms/pain control
- Eliminate root or cause of problem (if possible)
- Lessen/eliminate habits which caused the condition or made it worse
- Maintenance care (periodic balancing/tune-up to keep in good health)

On the following page, please check any boxes of symptoms you have had in the past 2 weeks.

**General**

- Chills
- Fevers
- Sweat easily
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold / hot)
- Thirst, no desire to drink
- Fatigue
- Sudden energy drop  
*Time of day:* \_\_\_\_\_
- Edema  
*Where:* \_\_\_\_\_
- Poor sleeping
- Tremors
- Poor balance
- Cravings
- Change in appetite
- Poor appetite
- Weight change  
*Gain / Loss* \_\_\_\_\_

**Skin and Hair**

- Rashes
  - Itching
  - Change in hair or skin
  - Ulcerations
  - Eczema
  - Oozing skin lesion
  - Hives
  - Pimples
  - Recent moles
  - Loss of hair
  - Dandruff
- Other hair or skin problems*  
\_\_\_\_\_

**Head, Eyes, Ears  
Nose, and Throat**

- Dizziness
- Migraines
- Headaches  
*When:* \_\_\_\_\_  
*Where:* \_\_\_\_\_
- Facial pain
- Glasses
- Poor vision
- Night blindness
- Blurry vision

- Color blindness
  - Blind field
  - Spots in front of eyes
  - Eye pain
  - Eye strain
  - Cataracts
  - Eye Dryness
  - Excessive tearing
  - Discharge from eyes
  - Poor hearing
  - Ringing in ears
  - Earaches
  - Discharge from ear
  - Nose bleeds
  - Sinus congestion
  - Nasal drainage
  - Grinding teeth
  - Teeth problems
  - Jaw clicks
  - Concussions
  - Recurrent sore throats
  - Hoarseness
  - Sores on lips/tongue
- Other head / neck problems*  
\_\_\_\_\_

**Cardiovascular**

- High blood pressure
  - Low blood pressure
  - Chest discomfort/pain
  - Heart palpitations
  - Cold hands or feet
  - Swelling of hands
  - Swelling of feet
  - Blood clots
  - Fainting
  - Difficulty in breathing
- Other heart/blood vessel problems:* \_\_\_\_\_

**Respiratory**

- Cough
  - Asthma/wheezing
  - Difficulty in breathing when lying down
  - Phlegm *Color?* \_\_\_\_\_
  - Coughing blood
  - Pneumonia
  - Bronchitis
- Other lung problems:* \_\_\_\_\_

**Gastrointestinal**

- Bad breath
  - Nausea
  - Vomiting
  - Heartburn
  - Belching
  - Indigestion
  - Diarrhea
  - Constipation
  - Chronic laxative use
  - Blood in stools
  - Black stools
  - Abdominal pain/cramps
  - Gas
  - Rectal pain
  - Hemorrhoids
- Other stomach or intestinal problems:* \_\_\_\_\_

**Genito-Urinary**

- Pain on urination
  - Urgency to urinate
  - Frequent urination
  - Blood in urine
  - Decrease in flow
  - Dribbling
  - Kidney stones
  - Impotency
  - Change of sexual drive
  - Sores on genitals
- Do you wake to urinate?*  
 Yes  No
- How often?* \_\_\_\_\_
- What color is your urine?*  
\_\_\_\_\_
- Other genital or urinary system problems?* \_\_\_\_\_

**Pregnancy and  
Gynecology**

- # of pregnancies:* \_\_\_\_\_
- # of births:* \_\_\_\_\_
- # premature births:* \_\_\_\_\_
- # of miscarriages:* \_\_\_\_\_
- # of abortions:* \_\_\_\_\_
- Age at first menses:* \_\_\_\_\_
- Length of full cycle:* \_\_\_\_\_
- Length of menses:* \_\_\_\_\_
- Last menses start date:* \_\_\_\_\_

- Heavy periods
  - Light periods
  - Painful periods
  - Irregular periods
  - Changes in body/psyche prior to menstruation
  - Clots
  - Vaginal discharge:
  - Menopause:  
*Age:* \_\_\_\_\_  
*Year:* \_\_\_\_\_
  - Postcoital bleeding
  - Vaginal sores
  - Breast lumps
  - Nipple discharge
- Do you practice birth control?*  
 Yes  No
- What type and for how long?*  
\_\_\_\_\_

**Musculoskeletal**

- Neck pain
  - Shoulder pain
  - Back pain
  - Elbow pain
  - Hand/wrist pain
  - Hip pain
  - Knee pain
  - Foot/ankle pain
  - Muscle pain
  - Muscle weakness
- Other pain?* \_\_\_\_\_

**Neuropsychological**

- Seizures
  - Areas of numbness
  - Weakness
  - Sleep disorder
  - Concussion
  - Violence potential
  - Vertigo
  - Lack of coordination
  - Bad temper
  - Depression
  - Easily stressed
  - Loss of balance
  - Poor memory
  - Anxiety
  - Substance abuse
- Have you ever been treated for emotional problems?*  
 Yes  No

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Last Physical Date: \_\_\_\_\_ Doctor: \_\_\_\_\_ Results: \_\_\_\_\_

**Habits** Please indicate below: None, Light, Moderate, or Heavy. Please add comments where significant

	Excessive	Moderate	Minimal	None	
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coffee:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appetite:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Energy Level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vitamins:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food Intake:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Teeth problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Salt Intake:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stress Level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Diet** Please give a general description of the food you eat during a "typical" day.

Morning: \_\_\_\_\_

Afternoon: \_\_\_\_\_

Evening: \_\_\_\_\_

Before bed: \_\_\_\_\_

Between meals: \_\_\_\_\_

Are you now, or have you ever been, on a restricted diet? Please describe the diet and give the start/stop dates:

\_\_\_\_\_  
\_\_\_\_\_

What medicines have you taken within the last 2 months? (prescriptions, vitamins, over-the-counter drugs, herbs)

\_\_\_\_\_  
\_\_\_\_\_

What allergies do you have? What reactions do you have to these chemicals, foods, etc?

\_\_\_\_\_  
\_\_\_\_\_