Health History Questionnaire (First Visit)

Today's Date _____ Patient's Name _____

Major Health Concern(s) _____ _____

_____ _____ _____

History of: (Check if applicable)

Self	Immediate Family	Disease/Illness (If yes, please specify)
____	_____	Cancer _____
____	_____	Diabetes _____
____	_____	High Blood Pressure _____
____	_____	Heart Disease _____
____	_____	Hepatitis _____
____	_____	Rheumatic Fever _____
____	_____	Thyroid Disease _____
____	_____	Seizures _____
____	_____	Allergies _____
____	_____	Asthma _____
____	_____	Alcoholism _____
____	_____	Stroke _____
____	_____	Tuberculosis _____
____	_____	Venereal Disease _____
____	_____	HIV (AIDS) _____
____	_____	Substance Abuse _____
____	_____	Mental Illness _____
____	_____	Weight Problem _____
____	_____	Other _____

Please check box or fill in the blank for each item that applies to you.

General:

☐Poor appetite ☐Excessive appetite ☐Fatigue ☐Insomnia
☐Cold hands ☐Cold feet ☐Chills ☐Cold abdomen
☐Cold back ☐Poor sleep ☐Cravings ☐Heavy sleep
☐Night sweats ☐Sweat easily ☐Fevers ☐Poor coordination
☐Tremors ☐Change in appetite ☐Vertigo ☐Bleeding
☐Bruise easily ☐Hearing loss ☐Joint pain ☐Strong thirst (hot/cold)
☐Sudden energy drop (time _____) ☐Depression ☐Emotional change
☐Weight gain/loss ☐Peculiar tastes/smells ☐Localized weakness (where _____)

Skin & Hair:

☐Rashes ☐Itching ☐Eczema ☐Lacerations
☐Hives ☐Pimples ☐Dandruff ☐Loss of hair
☐Purpura ☐Ulcers ☐Acne ☐Psoriasis
☐Change in hair texture ☐Change in skin texture

Head & Eyes + ENT:

☐Dizziness ☐Eyestrain ☐Color blindness ☐Night blindness
☐Eye pain ☐Mucus ☐Teeth problems ☐Gum problems
☐Cataracts ☐Glaucoma ☐Spots in eyes ☐Difficulty swallowing
☐Poor vision ☐Glasses ☐Blurry vision ☐Ringing in ears
☐Poor hearing ☐Earaches ☐Nose bleeds ☐Sinus problems
☐Jaw Clicks ☐Migraines ☐Dry throat ☐Recurrent sore throats
☐Dry mouse ☐Copius saliva ☐Grinding teeth ☐Sores on lips or tongue
☐Facial pain ☐Headaches ☐Concussions ☐Other head/neck problems (Specify _____)

Cardiovascular:

☐High blood pressure ☐Low blood pressure ☐Chest pain ☐Dizziness
☐Swelling in hands/feet ☐Irregular heartbeat ☐Palpitations ☐Blood clots
☐Difficulty breathing ☐Shortness of breath ☐Fainting ☐Phlebitis
☐Cold hands/feet ☐Other (Specify _____)

Respiratory:

☐Cough ☐Coughing blood ☐Bronchitis ☐Production of phlegm
☐Pneumonia ☐Tight chest ☐Wheezing ☐Painful breathing
☐Difficulty breathing (when lying down) ☐Asthma ☐Allergies
☐Emphysema ☐Easy winded

Gastrointestinal:

☐Nausea ☐Gas ☐Bad breath ☐Constipation
☐Pain/cramps ☐Vomiting ☐Belching ☐Rectal pain
☐Bloody stools ☐Diarrhea ☐Black stools ☐Hemorrhoids
☐Loss of appetite ☐Undesired weight loss ☐Indigestion ☐Parasites
☐Sensitive abdomen ☐Laxative use: how often_____/a week; type_____)
☐If problem with bowel movement, please specify the following:
Frequency of movements _____times/day or week
Color _____ Odor _____ Texture/form_____

Genito-Urinary

☐Pain on urination ☐Frequent urination ☐Blood in urine ☐Urgency to urinate
☐Kidney stones ☐Unable to hold urine ☐Impotency ☐Previous surgery
☐Wake up to urinate ☐Discolored urine ☐Scanty urination ☐Genital sores
☐Difficulty starting urination

Pregnancy & Gynecology (Females only):

☐# of pregnancies_____ ☐# of live births_____ ☐# of miscarriages_____
☐# of premature births_____ ☐# of abortions_____ ☐Age at first mense_____
☐Irregular periods ☐Period: # of days_____ ☐Painful periods
☐Light flow ☐Heavy flow ☐Clots ☐PMS ☐Breast lumps
☐Menopause ☐Last mense_____ ☐Last PAP_____ ☐Vaginal discharge
☐Vaginal sores ☐Fertility problems ☐Birth control: current type_____

☐Changes in body/psyche prior to menstruation: specify symptoms_____
_____

Neuropsychological:
☐Seizures ☐Depression ☐Anxiety ☐Easily stressed
☐Mood swings ☐Poor memory ☐Bad temper/irritability ☐Areas of numbness
☐Loss of balance ☐Lack of coordination ☐Disorientation
☐Treated for emotional problems ☐Considered/attempted suicide
☐Other neurological or psychological problems_____

Musculoskeletal:
☐Neck pain ☐Back pain ☐Muscle pains/spasms/cramping/soreness/weakness
☐Scoliosis ☐Arthritis ☐Recent sprains ☐Injuries
☐Foot pain ☐Weak joints ☐Joint pains: where_____

Please be prepared to describe the type and quality of pain.

Main problem you would like us to help you with? _____
What kind of treatment have you tried? _____
Have they helped alleviate the condition/problem? _____
Are you currently receiving treatment for your problem? _____

Past Medical History:
Surgeries: _____
_____
Significant trauma (i.e. car accidents, falls etc.) _____
_____
Any infectious diseases? (If yes, specify: _____)

Please list your medicines: (including prescription, OTC drugs, vitamins, herbs etc. taken within 3 months) _____
_____
Average or typical blood pressure: _____/_____ Average pulse rate: _____/min.
Allergies: _____

Family Medical History (General health):
Mother's side_____
Father's side _____
Siblings _____
If any of the above deceased, what was the cause? _____
Personal birth history (prolonged labor, forceps, Caesarean etc.)_____
Childhood health _____Location of upbringing _____
Current emotional health _____Current quality of life _____
Current relationship quality _____Current predominant emotion _____
Stress level _____ Favorite time of year _____ Worst _____
Hobbies and rec. _____ Regular exercise program? _____