



HEALTH HISTORY QUESTIONNAIRE



Please help us provide you with a complete evaluation by taking the time to complete this questionnaire completely. All of your information on this form will be kept confidential unless you sign a release for your medical records to be released. If you have any questions, please contact our front office staff or your provider.

What is/are the main problem(s) you would like us to help you with: \_\_\_\_\_  
\_\_\_\_\_

How long ago did this problem begin (be specific)?: \_\_\_\_\_  
\_\_\_\_\_

Was there a known cause/instigating factor for your problem? \_\_\_\_\_  
\_\_\_\_\_

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

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

What kinds of treatment have you tried?: \_\_\_\_\_  
\_\_\_\_\_

Past Medical History (please include date):  
 Cancer \_\_\_\_\_  Diabetes \_\_\_\_\_  Hepatitis \_\_\_\_\_  
 High Blood Pressure \_\_\_\_\_  Heart Disease \_\_\_\_\_  Rheumatic Fever \_\_\_\_\_  
 Thyroid Disease \_\_\_\_\_  Seizures \_\_\_\_\_  Venereal Disease \_\_\_\_\_  
 Other: \_\_\_\_\_

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

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

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

Birth History (prolonged labor, forceps delivery, etc.): \_\_\_\_\_  
\_\_\_\_\_

Allergies (drugs, chemicals, foods/result): \_\_\_\_\_  
\_\_\_\_\_

Family Medical History (check):  
 Diabetes  Cancer  High Blood Pressure  Heart Disease  
 Stroke  Seizures  Asthma  Allergies  
 Other: \_\_\_\_\_

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): \_\_\_\_\_  
\_\_\_\_\_

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

Do you have a regular exercise program?  Yes  No Please describe: \_\_\_\_\_

Have you ever been on a restricted diet?  Yes  No What kind?: \_\_\_\_\_

### Please Describe Your Average Daily Diet

Morning \_\_\_\_\_

Afternoon \_\_\_\_\_

Evening \_\_\_\_\_

How many packs of cigarettes do you smoke per day? \_\_\_\_\_ How much coffee, tea or cola do you drink per week? \_\_\_\_\_

How much alcohol do you drink per week? \_\_\_\_\_ Please describe any use of drugs for non-medical purposes: \_\_\_\_\_

### Please Check Any Symptoms That have Been Persistent in the Last Three Months

#### General

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

#### Skin and Hair

- Rashes
- Itching
- Change in hair or skin
- Ulcerations
- Eczema
- Oozing on 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 tear
- 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 or tongue
- Other head or 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 or blood vessel problems: \_\_\_\_\_

#### RESPIRATORY

- Cough
- Asthma/wheezing
- Pain with a deep breath
- Difficulty in breathing when lying down
- Production of phlegm what 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 or cramps
  - Gas
  - Rectal pain
  - Hemorrhoids
  - Other stomach or intestinal problems:
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**GENITO-URINARY**

- Pain on urination
  - Urgency to urinate
  - Frequent urination
  - Blood in urine
  - Decrease in flow
  - Unable to hold urine
  - Dribbling
  - Kidney stones
  - Impotency
  - Change of sexual drive
  - Sores on genitals
  - Other genital or urinary system problems:
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- Do you wake up to urinate?  
 Yes    No  
 How often?
- 
- Any particular color to your urine?
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**PREGNANCY AND GYNECOLOGY**

- Number of pregnancies \_\_\_\_\_
  - Number of births \_\_\_\_\_
  - Premature births \_\_\_\_\_
  - Miscarriages \_\_\_\_\_
  - Abortions \_\_\_\_\_
  - Age at first menses \_\_\_\_\_
  - Period between menses \_\_\_\_\_
  - Duration \_\_\_\_\_
  - First date of last menses:  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
  - Unusual character
    - heavy
    - light
  - Painful periods
  - Irregular periods
  - Changes in body/psyche prior to menstruation
  - Clots
  - Menopause:
    - Age \_\_\_\_\_
    - Year \_\_\_\_\_
  - Vaginal discharge
  - Postcoital bleeding
  - Vaginal sores
  - Last Pap \_\_\_\_\_
  - Breast lumps
  - Nipple discharge
  - Do you practice birth control?  
 Yes    No
  - What type and for how long?
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**MUSCULOSKELETAL**

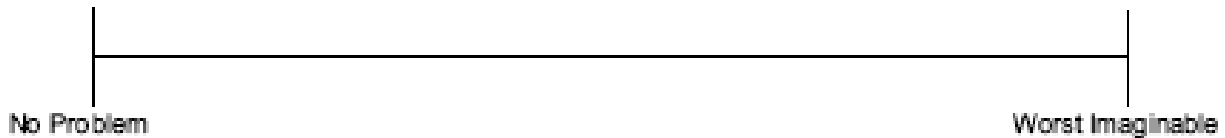
- Neck pain
- Shoulder pain
- Back pain
- Elbow pain
- Hand/wrist pains
- Hip pain
- Knee pain
- Foot/ankle pains
- Muscle pains
- Muscle weakness

**NEUROPSYCHOLOGICAL**

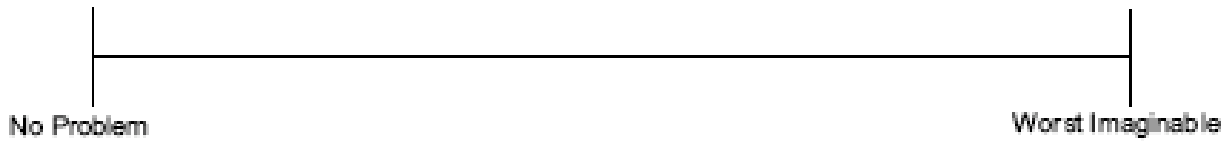
- Seizures
  - Areas of numbness
  - Weakness
  - Sleep disorder
  - Concussion
  - Bad temper
  - Loss of control/violence potential
  - Vertigo
  - Lack of coordination
  - Depression
  - Easily susceptible to stress
  - Loss of balance
  - Poor memory
  - Anxiety
  - Substance abuse
  - Other neurological or psychological problems
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- Are you currently pregnant?    Yes    No    N/A
- Are you currently in menopause?    Yes    No    N/A
- Have you ever been tested for:    HIV    Hepatitis A    Hepatitis B    Hepatitis C    TB
- Are you currently in a drug or alcohol treatment program?    Yes    No
- Have you ever been treated for emotional problems?    Yes    No
- Have you ever considered or attempted suicide?    Yes    No

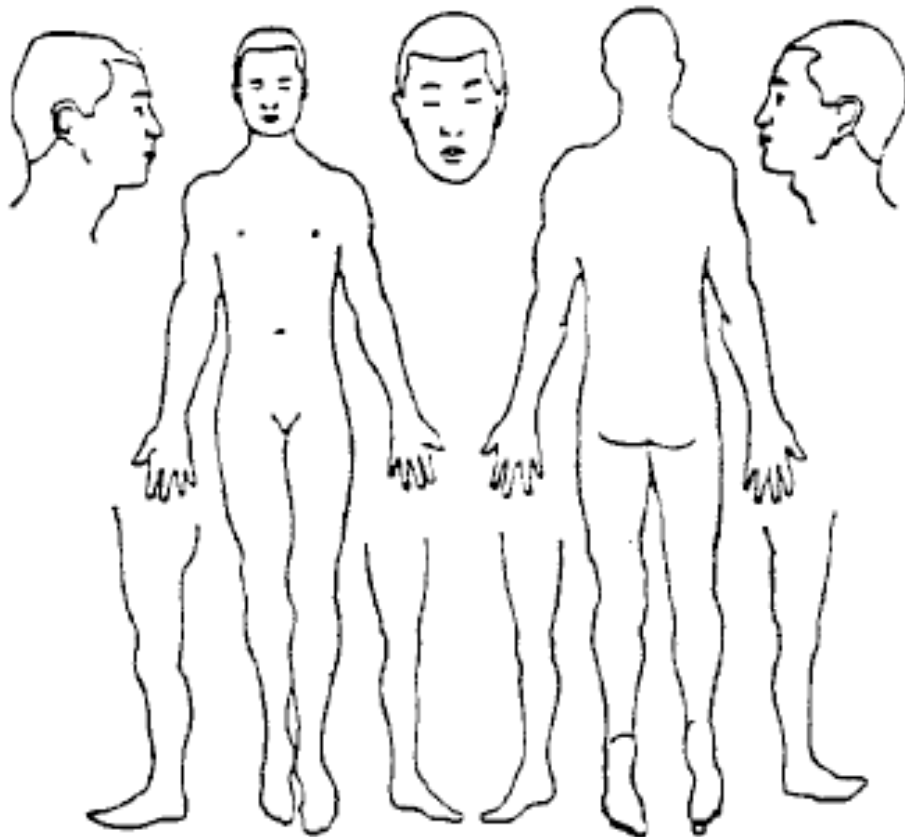
**Please note the degree of severity of your problem now:**



**Please note the greatest degree of severity of your problem within the last week:**



**Indicate painful or distressed areas:**



**Comments** (please tell us any other problems you would like to discuss): \_\_\_\_\_

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