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HEALTH HISTORY QUESTIONAIRE

Name ______________________________ **Date** ______________________

Chief Concern____
____

Other Concerns ____
____
____

When did these problems begin? (Be Specific) ____________________________
____
____

How do these complaints affect your daily activities?(work, sleep, relationships)____________
____
____

Have you been diagnosed? If so, what is the diagnosis? ______________________
____

What kinds of treatments have you tried? _______________________________
____

Are you Pregnant? ________________ **Do you have a pacemaker?** ______________

Medical History for the past six (6) months (include dates) ____________________
____

Family Medical History & significant illness (please circle) Cancer Diabetes Hepatitis
Heart Disease High Blood Pressure Stroke Rheumatic Fever Seizures Thyroid Disease
Venereal Disease Allergies Asthma Other_______________________________
Surgeries ____
____
____

Significant Trauma (auto accidents, injuries, etc.) ___________________________
____
____

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Your Birth History (prolonged labor, forceps delivery, etc.) ____

____

Allergies (drugs, chemicals, foods) ____

____

Medications taken in the last two (2) months (include vitamins, drugs, herbs, birth control and over the counter) ____

____

____

Lifestyle / Occupational Stress (chemical, physical etc.) ___________________________________

____

Do you exercise? _____________ **How Regularly**? _____________ **Describe** ___________________

____

Have you ever been on a restricted diet? _______________ **What Kind**? _____________________

____

Please describe your average daily diet including meals and snacks:

Morning: ____

____

Afternoon:____

____

Evening: ____

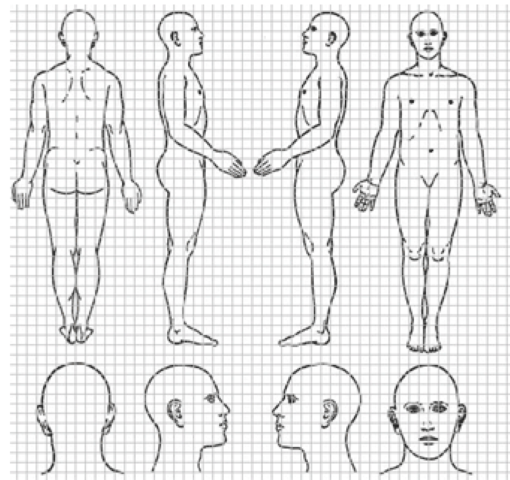
____

Is there anything else you would like us to know about you? ______________________________

____

____

Indicate any painful or distressed areas



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Please check if you have had within the last three (3) months:

____ Poor appetite	_____ Poor sleeping	_____ Fatigue
____ Fevers	_____ Chills	_____ Night sweats
____ Sweats easily	_____ Tremors	_____ Cravings
____ Localized weakness	_____ Poor balance	_____ Change in appetite
____ Peculiar tastes or smells	_____ Weight loss	_____ Weight gain
____ Sudden thirst (cold or hot drinks)		

Sudden energy drop (what time of day?) ____

SKIN and HAIR

____ Rashes	_____ Ulcerations	_____ Hives
____ Itching	_____ Eczema	_____ Pimples
____ Dandruff	_____ Loss of hair	_____ Recent moles
____ Change in hair or skin texture		

Any other hair or skin problems? ____

HEAD, EYES, EARS, NOSE and THROAT

____ Dizziness	_____ Concussions	_____ Migraines
____ Glasses	_____ Eye strains	_____ Eye pain
____ Poor Vision	_____ Night blindness	_____ Color blindness
____ Cataracts	_____ Blurry vision	_____ Earaches
____ Ringing in ears	_____ Poor hearing	_____ Spots in front of eyes
____ Sinus problems	_____ Nose bleeds	_____ recurrent sore throats
____ Grinding teeth	_____ Facial pain	_____ Sores on lips or tongue
____ Teeth problems	_____ Jaw clicks	

HEADACHES? Where and when?____

Any other head and / or neck problems? ____

CARDIOVASCULAR

_____ High blood pressure	_____ Low blood pressure	_____ Chest pain
____ irregular heartbeat	_____ dizziness	_____ Fainting
____ Cold hands or feet	_____ swelling of hands	_____ Swelling of feet
____ Blood clots	_____ Phlebitis	_____ Difficulty breathing

ANY OTHER HEART OR BLOOD VESSEL PROBLEMS?______________________________________

____

(over)

RESPIRATORY

____ Cough ____ Coughing blood ____ Asthma
____ Bronchitis ____ Pneumonia ____ Pain with deep breath
____ Difficulty breathing when lying down
____ Production of Phlegm What color?____________
Any other lung problem? ____

GASTROINTESTINAL

____ Nausea ____ Vomiting ____ Diarrhea
____ Constipation ____ Gas ____ Belching
____ Black stools ____ Blood in stools ____ Indigestion
____ bad breath ____ Rectal pain ____ Hemorrhoids
____ Chronic laxative use
Any other problems with your stomach or intestines?______________________________

GENITO-URINARY

____ Pain on urination ____ frequent urination ____ Blood in urine
____ Urgency to urinate ____ unable to hold urine ____ Kidney stones
____ decrease in flow ____ impotency ____ Sores on genitals
Do you wake up to urinate? How often? ______________________________
Any particular color to your urine? ______________________________
Any other problems with your genitals or urinary system? ______________________

PREGNANCY & GYNOCOLOGY

____ Number of pregnancies ____ Number of births ____ Premature birth
____ Miscarriages ____ Abortions ____ Age @ first menses
____ Period between menses ____ Duration ____ first day of last menses
____ Unusual character (heavy or light) ____ Irregular periods
____ Painful periods ____ Clots ____ Last PAP
____ Vaginal discharge ____ Vaginal sores ____ Breast lumps
____ Changes to body / psyche prior to discharge
Do you practice birth control?____ What type and for how long?____________________

MUSCULOSKELATAL

____ Neck pain ____ Muscle pains ____ Knee pains
____ back pain ____ Muscle weakness ____ Foot/ankle pains
____ Hand/wrist pains ____ Shoulder pain ____ Hip pain

ANY OTHER JOINT OR BONE PROBLEMS? ______________________________

(over)

NEUROPSYCHOLOGICAL

____ Seizures ______ Dizziness ______ Loss of balance
____ Areas of numbness ______ Lack of coordination ______ Poor memory
____ Concussion ______ Depression ______ Anxiety
____ Bad temper ______ Easily susceptible to stress
Have you ever been treated for emotional problems?___________________________________
Have you ever considered or attempted suicide? _______________________________________
Any other neurological or psychological problems? _____________________________________

COMMENTS:

(over)