		DATE
NAME	**DOB**	**For office use only:**

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential.
Your responses will become part of your medical record.

Personal Medical History

Childhood Illnesses: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Birth Trauma (your own)

Surgeries

Year	**Reason**	**Hospital/Surgeon**

Other Hospitalizations

Year	**Reason**	**Hospital/Physician**

Have you ever had a blood transfusion?	☐ Yes ☐ No
Do you have any bleeding disorders (eg., hemophilia)?	☐ Yes ☐ No
Do you take a "blood thinner" (eg., warfarin, aspirin)?	☐ Yes ☐ No

Have you been diagnosed with any of the following?

☐ Alcohol	☐Depression	☐Hernia	☐Pleurisy	☐Stroke
☐Anemia	☐Emphysema	☐Herpes	☐Pneumonia	☐Thyroid Disorder
☐Appendicitis	☐Epilepsy	☐High Blood Pressure	☐PTSD	☐Trauma, Major
☐Arteriosclerosis	☐GERD/Reflux	☐HIV/AIDS	☐Sexually Transmitted Infection	☐Tuberculosis (TB)
☐Asthma	☐Goiter	☐MRSA	☐Scarlet Fever	☐Typhoid Fever
☐Cancer	☐Gout	☐Multiple Sclerosis	☐Seizures	☐Ulcers
☐COPD	☐Heart Disease	☐Pacemaker	☐Sleep Apnea	☐Whooping Cough
☐Diabetes	☐Hepatitis	☐Peripheral Neuropathy	☐Other (Specify)	

Use the following space to explain any of the above diagnoses or provide additional information if necessary.

Name: DOB:

List your prescribed medication and over-the-counter medication, including vitamins and herbs

Name the Drug/Herb	Strength/Dose	Reason for taking

Allergies (Drug, food, or environment)

Type of allergy	Reaction You Had

Family Health History

	Significant Health Problems		Significant Health Problems
Mother		Children	
Father			
Siblings			
Grandparents			

HEALTH HABITS AND PERSONAL SAFETY

EXERCISE & PHYSICAL ACTIVITY	☐ Sedentary (No exercise)	**Frequency of Exercise**
	☐ Mild exercise/activity (ex: taking the stairs, walking, tai chi, yoga, light gardening, household work)	
	☐ Moderate exercise/activity (ex: fast walking, dancing, general gardening, golf, swimming)	
	☐ Vigorous exercise/activity (ex: jogging, hiking, competitive sports, fast biking, heavy lifting/carrying)	
PERSONAL SAFETY	Do you have frequent falls? ☐ Yes ☐ No How recent was last fall?	
	Do you have vision loss? ☐ Yes ☐ No Hearing loss? ☐ Yes ☐ No	
	Physical and/or mental abuse is a serious public health concern in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Yes ☐ No	
	Do you have regular contact with occupational hazards? ☐ Yes ☐ No Please describe:	

Name: DOB:

HEALTH HABITS (continued)	Do you use any tobacco products? ☐ Yes ☐ No # of years Or year quit:	
	➢ If yes, give number/amount per day: ☐Cigarettes: _____ ☐Pipe: _____ ☐Cigars: ____ ☐Chew/Dip: _____ ☐Vape:_____mg	
	Amount of caffeine daily: ☐ None ☐ Coffee _____ ☐ Tea _____ ☐ Soft Drinks/Energy Drinks____	
	Do you drink alcohol? ☐ Yes ☐ No # of drinks:_____per day/week/month (circle most appropriate)	
	• Are you concerned about how much alcohol you consume? ☐ Yes ☐No	
	Do you currently use recreational or street drugs? ☐Yes ☐No	Have you ever used drugs intravenously? ☐ Yes ☐ No

PLEASE INDICATE IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING:

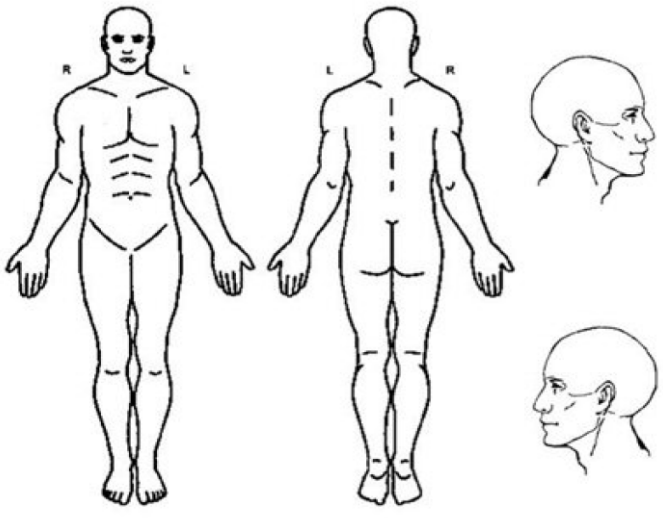
Temperature & Perspiration	☐Cold-natured / prefer to bundle up	☐Cold Hands	☐Cold Feet	☐Strongly prefer hot drinks	☐Chills
	☐Hot-natured	☐Heat in palms or soles	☐Flushing of face, neck, or chest	☐Strongly prefer cold drinks	☐Hot flashes or feverish sensation
	☐Absence of sweating	☐Sweat easily	☐Spontaneous sweating	☐Night sweats	Do you have a seasonal preference?
Thirst	☐Excessive/frequent thirst	☐Lack of thirst	☐Thirst, but no desire to drink or drink small amount		
	Estimate fluid intake:	☐ Water: (# glasses daily)	☐ Fruit Juices: (# glasses daily)	☐ Soft drinks/energy drinks:	
Appetite & Digestion	Current weight:_____lbs ☐Recent weight *gain* _____lbs ☐ Recent weight *loss*_____lbs				
	Are you dieting? ☐Yes ☐ No	If yes, are you on a physician or dietitian prescribed medical diet? ☐Yes ☐ No			
	Are you vegan or vegetarian? ☐Yes ☐No	Cravings or flavor preferences?			
	Rank **sweets** intake: ☐High ☐Med ☐Low	Rank **salt** intake: ☐ High ☐ Med ☐ Low			
	Number of meals & snacks daily:	Do you have any food sensitivities? ☐Yes ☐No			
	☐Taste in mouth (describe)		☐Moderate appetite	☐Poor appetite	☐Large appetite
	☐Burning feeling in stomach region	☐Cold feeling in stomach region	☐Empty or uncomfortable feeling in stomach region	☐ Abdominal rumbling (not from hunger)	☐Constant hunger
	☐Bloating after eating	☐Stuffiness or fullness in abdomen	☐Stomach pain / Epigastric pain	☐Pain related to eating	☐ Hunger, but no desire to eat
	☐ Belching frequent	☐Nausea	☐Vomiting	☐Abdominal pain	☐ Bad breath

Name: DOB:

Bowel Movements	Frequency:	Color:	Appearance of stool:		Strong Odor? ☐Yes ☐ No
	☐Diarrhea frequently	☐Constipation	☐Mucus in stool	☐Blood in stool	☐Black or tar-colored stool
	☐Urgent bowel movement	☐Incomplete bowel movement	☐Flatulence (Gas)	☐Intestinal pain, cramping or spasms	☐Laxative use
	☐Hemorrhoid	☐Rectal bleeding	☐Burning sensation at anus	☐Itching at anus	☐Rectal Prolapse
Urination	Is amount of urine consistent with fluid intake? ☐ Yes ☐ No			Urine color:	
	☐Blood in urine	☐Cloudy urine	☐Pain on urination	☐Burning urination	☐Frequent urination
	☐Urgent urination	☐Difficult/unable to hold urine	☐Incomplete urination	☐Difficulty starting urination	☐Weak urine flow
	☐Dribbling after urination	☐Bed-wetting	☐Kidney stone	Do you usually get up to urinate during the night? ☐ Yes ☐ No If yes, how many times? _____	
Sleep & Energy	Avg. hours of sleep per night:	☐Poor sleep quality	☐Light sleeper	☐Heavy sleeper	☐Restless sleep
	☐Frequent waking	☐Difficulty falling asleep	☐Unable to remember dreams	☐Dream-disturbed sleep	☐Frequent nightmares
	☐Low energy	☐Feeling of heaviness	☐Restless feeling	☐Daytime sleepiness	☐ Sleepiness after eating
Psychological & Neurological	☐ Cry or laugh without reason	☐ Speech difficulty	☐ Poor memory	☐ Difficulty concentrating	☐ Anxiety
	☐ Mental Restlessness	☐ Racing thoughts	☐ Irritability	☐ Easily stressed	☐ Worrying or Overthinking
	☐ Lack of emotion	☐ Depression	☐ Considered or attempted suicide	☐ Abuse survivor	☐ Seeing a therapist
	☐ Seizures	☐ Tics, twitching	☐ Numbness	☐ Nerve pain	☐
Breathing	☐Shortness of Breath	☐Difficulty breathing when lying down	☐Asthma/wheezing	☐Tightness in chest	☐Frequent yawning
	☐Frequent sighing	☐Difficulty inhaling	☐Difficulty exhaling	☐ Pain in chest/torso when coughing	☐ Pain when inhaling
	☐Cough: Wet or dry?	If wet, is phlegm thick or thin?	Color of phlegm:		Blood in sputum?
Circulation	☐High blood pressure	☐Low blood pressure	☐Blood clots	☐Varicose veins	☐Chest pain
	☐Fainting	☐Light-headed	☐Dizzy on standing	☐Poor circulation	☐Heart palpitation
	☐Racing/fast heartbeat	☐Irregular heartbeat	☐Stuffy or oppressive feeling in chest	☐Bleed or bruise easily	☐Edema

Name: DOB:

Head, Ears, Eyes, Nose, Throat	☐Glasses (Since:)	☐Eye pain	☐Dry eyes	☐Red eyes	☐Sensitivity to light (photophobia)
	☐Itchy Eyes	☐Spots before eyes, "floaters"	☐Blurred vision	☐Night blindness	☐ Watery eyes, frequent tearing
	☐Myopia, Near-sighted	☐Presbyopia, Far-sighted	☐Cataracts	☐Glaucoma	☐Macular degeneration
	☐Facial pain	☐Jaw pain/TMJ	☐Grinding Teeth	☐Teeth problems	☐Gum problems
	☐Dry mouth	☐Excess saliva	☐Mouth sores (including lips & tongue)	☐Pain in mouth	☐ Taste in mouth -- Describe:
	☐Difficulty swallowing	☐Lump in throat	☐Dry or itching throat	☐Hoarseness, losing voice	☐Recurring sore throat
	☐Swollen glands	☐Enlarged thyroid	☐ Phlegm in throat		
	☐Full feeling in ears	☐Earaches	☐Poor hearing	☐Ringing in ears (tinnitus):	☐High pitch or ☐Low pitch
	☐Nasal discharge Color:		☐ Nasal congestion	☐Post-nasal drip	☐Nosebleeds
	☐Sinus problems	☐Vertigo or dizziness	☐Headaches	☐Migraines	☐Concussions or TBI
Skin, Hair, Nails	☐ Weak/brittle nails	☐ Rashes	☐ Hives	☐ Skin ulcers	☐ Slow or poor wound healing
	☐ Frequent fungal infections	☐ Psoriasis	☐ Eczema	☐ Acne	☐ Dry skin
	☐ Itchy skin	☐Rosacea	☐Other skin problems:		
	☐ Change in hair texture	☐ Premature grey hair	☐ Hair loss	☐ Itchy scalp	☐ Dandruff
Musculo-skeletal	☐ Muscle weakness, lack of strength	☐ Muscle cramps	☐ Muscle spasm	☐ Muscle pain	☐ Neck pain
	☐ Upper back pain	☐ Low back pain	☐ Joint pain	☐ Rib pain	☐ Shoulder pain
	☐ Limited range of motion	☐ Limited use	☐ Other: (Describe)		



Pain Scale [0-10]
0=no pain
10=highest pain

(P) =Pain
(T) =Tension
(∅) =Knot/Trigger Point
(S) =Swelling
(B) =Bruise
(W) =Weakness
(∴) =Rash/Irritation
(C) =Cut
(H) =Burn
♯ =Sharp
♭ =Dull
♮ =Normal

Feel free to use the diagram to the left to indicate the location(s) of **pain or other symptoms** you have been experiencing.

Name:	DOB:

For Women Only				
Are you currently pregnant or are you trying for a pregnancy?			☐ Yes ☐ No	
Are you breastfeeding?			☐ Yes ☐ No	
▪ Number of pregnancies: Number of live births: Number of premature births:				
▪ Please indicate if you have had a D&C, hysterectomy, or Cesarean?				
Age at onset of menstruation:		Age at menopause:		
First day of last period:		Date of last PAP & pelvic exam:		
Period every _ days (length of cycle)		Duration of flow:_____days		
Have you experienced any of the following symptoms?				
☐ Painful periods	☐ Irregular periods	☐ Heavy periods	☐ Scanty periods	☐ Clots present
☐ Spotting between periods	☐ Vaginal discharge between periods	☐ Vaginal dryness	☐ Vaginal odor	☐ Pain at ovulation (Mittelschmerz)
☐ Breast lumps	☐ Increased libido	☐ Decreased libido	☐ Genital area pain	☐ Bearing-down sensation or contraction in genitals
Have you experienced any of the following symptoms before or during your period?				
	☐ Cramping	☐ Swelling of extremities	☐ Abdominal bloating	☐
☐ Breast tenderness & distension	☐ Cravings for sweets	☐ Appetite changes	☐ Low back pain	☐ Generalized aches and pains
☐ Heart palpitations	☐ Headaches or Migraines	☐ Dizziness or faintness	☐ Diarrhea	☐ Constipation
☐ Mood swings	☐ Irritability	☐ Anxiety	☐ Depressed	☐ Forgetfulness
☐ Difficulty concentrating	☐ Restless or nervous tension	☐ Confusion	☐ Crying	☐ Insomnia
Other symptoms:				

For Men Only				
☐ Prostate enlargement	☐ Problems emptying your bladder completely	☐ Force of your urination decreased	Other urination problems:	
☐ Difficulty with erection or ejaculation	☐ Nocturnal emission	☐ Burning discharge from penis	☐ Bearing-down sensation or contraction in genitals	☐ Genital area pain
☐ Increased libido	☐ Decreased libido	☐ Other:		