

Health History Questionnaire

Thank-you for taking the time to fill this questionnaire out.

Pg. 1

Name _____ DOB _____ Date _____

Address _____ City _____ Zip _____

Phone Home: _____ Cell: _____ Age _____

E-mail Address: _____

How did you hear about us?

How would you describe your general health?

Excellent ___ Good ___ Fair ___ Poor ___

Main reason for today's visit:

When and how do you believe the problem first began (if applicable)?

Other concerns I would like to discuss if there is time today:

Personal Medical History (check those that apply)

Heart disease or Heart Attack (please specify type and procedures, if any) _____

Cancer (type, date, diagnosed and treatments received) _____

Thyroid problems _____

Digestive Issues _____

High Blood pressure _____

Mental Health problems _____

Diabetes _____

Osteoporosis/Osteopenia _____

Arthritis _____

High Cholesterol _____

Pg 2: Name _____

Women only

Age at onset of period _____ date of last menstrual period _____

Any difficulty with periods? _____

How many pregnancies have you had? _____ Any interrupted pregnancies? _____

Have you had a hysterectomy or ovaries removed? _____

Have you ever taken Birth control pills or hormone replacement? _____

Men only

Do you have a decrease in libido (sex drive)? _____

Do you have a decrease in strength and/or endurance? _____

Have you lost height? _____

Have you noticed a recent deterioration in your ability to play sports or in your work performance? _____

Do you have difficulty emptying your bladder completely? _____

Past Surgical History (please list all prior operations with dates):

Allergies

Medicinal allergies:

Environmental allergies:

Food allergies:

Pg 3: Name _____

Medications and dosages:

Health Maintenance:

Pap:

Bone Density:

Mammogram

Colonoscopy:

PSA:

Dental exam:

General Physical

Name of Primary MD

Supplements and Vitamins:

Family medical history (please list any major illnesses/problems):

Father:

Mother:

Siblings:

Pg 4: Name _____

Personal/Social History

Marriage history: _____ Marital Difficulty? _____

Who lives at home with you? _____

Children (ages) and health status _____

Occupation: _____ Employer: _____ Hours: _____

Exercise: Do you exercise regularly? No _____ Yes _____
If so, what type and how often? _____

Do you have a regular Spiritual practice? _____

Do you have social support? _____

What do you do for relaxation/hobbies? _____

Sleep pattern: How many hours of uninterrupted sleep do you generally get? _____

Please rate your quality and quantity of sleep (1 being poor and 10 being excellent)

Please rate your energy level (10 being plentiful, 1 being very low level): _____

Please rate your general mood (10 being balanced and manageable and 1 being unmanageable) _____

Please circle any that apply and average amount per day

Tobacco

Recreational drugs

Alcohol

Pg 5: Name _____

Diet and Nutrition

Please describe your overall diet and your favorite food:

For breakfast I usually eat:

For Lunch:

For Dinner:

Usual Snack:

Please circle all that apply and the estimated amount per day

Fast food/junk food _____ Soda _____ Caffeine _____

Artificial sweeteners _____

Anything else that you would like for us to know about your physical, mental, emotional or spiritual health?

For health care provider only

ROS:

Gen:

Derm:

HEENT:

Resp:

CV:

GI:

Gyne/GU:

MS:

Neuro:

Psy: