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Health History Questionnaire

All material in this questionnaire is strictly confidential and will become part of your medical record.

Today's Date: ______________________________

Last Name: ______________________________

First Name: ______________________ Middle Name: ______________________

DOB: ___/___/___ Age: _____ Gender: Female Male Prefer not to state

Home Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Home Phone: ______________________ Cell Phone: ______________________

Work Phone: ______________________ Email: ______________________

Preferred Daytime Contact Phone: Home Cell Work

Race/Ethnicity: ______________________________

Relationship status: Single Married Divorced Separated Widowed Partnered

Occupation: ______________________ Employer: ______________________

PCP Name & Phone Number: ______________________________

Names of Specialists (if any): ______________________________

Date of last physical: ______________________________

Referred by: ______________________________

Main reason for visit: ______________________________

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REVIEW OF SYSTEMS

GENERAL	YES	NO
Recent fever		
Anemia		
Night sweats		
Swollen glands		
Undue tiredness		
Unexplained weight loss		
Weight gain		
HEAD		
Tension or frequent headaches		
Fainting spells		
Hair change		
Convulsions		
EYES		
Glasses		
Discharge		
Pain		
Blurred vision		
Glaucoma		
Cataracts		
NECK		
Goiter		
Thyroid trouble		
Stiffness		
BREASTS		
Lumps		
Discharge		
HEART		
Chest pain or pressure on exertion		
Shortness of breath:		
On exertion		
At rest		
Use more than one pillow to sleep		
Swelling of ankles		
Heart palpitations, pounding, or skipping		
High blood pressure		
Heart murmur		
SKIN		
Rashes		
Lumps		
Easy bruising		
Eczema		
Psoriasis		
EXTREMITIES		
Joint pain or swelling		
Varicose veins		
Paralysis		
Weakness		
Numbness		
Pain on walking		
Back trouble		

GASTROINTESTINAL	YES	NO
Loss of appetite		
Indigestion		
Heartburn		
Nausea		
Vomiting		
Vomiting blood		
Diarrhea		
Constipation		
Blood in stool		
Pale stools		
Abdominal pain Upper Lower		
Gall bladder problems		
Food intolerance		
What foods?		
NOSE		
Drainage		
Bleeding		
Snoring		
MOUTH		
Dentures		
Sore throat		
Swallowing difficulty		
Hoarseness		
EARS		
Hearing loss		
Ringing		
Discharge		
Pain		
CHEST		
Cough		
Phlegm Colored Clear		
Pain in any part of chest/upper back		
Blood in mucus		
Wheezing		
Unable to lay flat		
GENITO-URINARY		
Pain or burning on passing water		
Frequency		
Blood in urine		
Trouble starting urine		
Up at night to urinate		
How many times?		
Leakage of urine		
Pain or trouble with sexual intercourse		
NERVOUS SYSTEM		
Depression		
Nervousness		
Trouble sleeping		
Excessive worry		
Suicidal thoughts		

Past & Present Medical Conditions

	Yes	No	Date
Headaches			
Stroke			
Seizures			
Pneumonia			
Diabetes (Type 1 or Type 2)			
Thyroid Disease (Low or High)			
Glaucoma			
Macular Degeneration			
Hearing Loss			
High Blood Pressure			
Blood Clots □ Pulm Emobli (lung clots) □ DVT (leg clots)			
Heart Burn, Reflux			
Stomach Ulcers			
Heart Disease □ Coronary Disease □ MI/heart attacks □ Congestive Heart Failure □ Atrial Fibrillation □ Angina □ Valve Disorder			
High Cholesterol			
Gastrointestinal Bleeding			
Hepatitis (A, B, or C)			
HIV / AIDS			
Chronic Wounds			
Cancer (specify type)			
Urinary Tract Infections			
Incontinence			
Kidney Stones			
COPD (Emphysema, Bronchitis)			
Asthma			
Depression			
Bipolar Disorder			
Anxiety			
Fibromyalgia			
Chronic Fatigue Syndrome			
Arthritis			
Gout			
Osteoporosis			
Prostate Disease			
Breast Disease			
Erectile Dysfunction			
Other:			

Have you had Chicken Pox Measles Mumps Polio Rheumatic Fever

Past Surgeries & Hospitalizations (indicate date if known)

☐ None ______________________________

☐ Cataracts ___________________________

☐ LASIK ______________________________

☐ Tonsillectomy _______________________

☐ Thyroidectomy ______________________

☐ Adenoidectomy ______________________

☐ Coronary Bypass _____________________

☐ Cardiac Stents _______________________

☐ Pacemaker __________________________

☐ Heart Valve _________________________

☐ Gall Bladder _________________________

☐ Appendectomy _______________________

☐ Bowel/Stomach Resection ______________

☐ Hemorrhoidectomy ___________________

☐ Bariatric Surgery _____________________

☐ Hysterectomy _______________________

☐ Endoscopy __________________________

☐ Colonoscopy ________________________

☐ Hernia _____________________________

☐ Spinal Surgery _______________________

☐ Tubal Ligation _______________________

☐ Bladder Surgery ______________________

☐ Prostate Surgery/resection ____________

☐ C-section ___________________________

☐ Orthopedic/joints _____________________

☐ Other ______________________________

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Prescribed pharmaceutical and/or nutraceutical medication & dosages if known:

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OTC drugs/vitamins/supplements/herbs & dosages if known:

____

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____

____

____

Known drug allergies/sensitivities: ______________________________________

Known food allergies/sensitivities: ______________________________________

Known environmental allergies: ____

Family History

	Mother	Father	Siblings	Grandparents
Heart Disease				
Diabetes				
Bleeding problem				
High blood pressure				
Cancer				
TB				
Stroke				
Other				

Is your mother alive? □ Yes □ No, cause of death: ___________________________

Is your father alive? □ Yes □ No, cause of death: ___________________________

Lifestyle Questions

Relationship status: □ Single □ Married □ Domestic Partnership □ Divorced □ Other

Do you have children? □ No □ Yes, I have ___ children and they are aged: ________

Are you trying to lose weight? No Yes If yes, how many pounds? ________________

Within the past 5 years, your: Highest Weight: ___________ Lowest weight: ___________

Are you following a diet? No Yes

If yes, type: Doctor Prescribed Atkins Mediterranean South Beach Raw Food

Vegan The Zone Vegetarian Weight Watchers NutriSystem Jenny Craig

Macrobiotic Cookie Glycemic Index Other: ______________________

Do you exercise? No Yes If yes, what type of exercise? ______________________

How many times per week? ______________ How many minutes per day? ________________

Have you ever been a member at a gym? _________ Worked with personal trainer? ___________

Do you drink alcohol? No Yes What is the frequency? ______________________

Are you dependent on alcohol? ___________ If so, for how many months/years? ______________

What is/are your preferred alcoholic beverage(s)? ______________________

Do you currently abuse recreational or prescription drugs? No Yes

For how long and what types? ______________________

Do you smoke? No, never I used to for this many years: ______ Packs per day: ______________

Yes, currently. Number of packs daily: __________ Since age: __________________

How many hours of sleep do you get? ______ Is it refreshing/restorative? ______________________

Do you take naps during the day? No Yes

Do you wake up in the middle of the night? No Yes

How many times and why? ____

Have you ever been exposed to chemicals? ____

Do you drink coffee? No Yes _____cups daily and type(s) ___________________________

Do you use sweeteners? No Yes, I use this type: __________________________________

How many glasses of water do you drink daily? _____ Type of water? __________________________

What types of cravings do you have? Sweet Salty Fatty Carbs

What are your main sources of protein? ____

How many fruits and vegetables do you eat daily? _________ Types? ___________________________

How often do you eat fast food? ___________ How many meals do you eat daily? ________________

Do you eat breakfast? No Yes, I eat: ____

____

Describe your lunch: ____

____

Describe your dinner: ____

____

Do you snack between meals? No Yes, I snack on: ______________________________________

____

Have you ever seen a therapist or a life coach? ____

At what age did you feel your best? Or do you think it is yet to come? __________________________

What do you enjoy most in life? ____

What are you most scared of in life? ____

What are your hobbies? ____

____

Are you religious or spiritual? ____

Do you enjoy your job? ___________________________ Do you feel fulfilled in life? ________________

What are your life stressors? ____

Best describe your sexual orientation: ____

Have you ever been abused (physically, emotionally, sexually)? _________________________________

If you are in a relationship, is it healthy? ___________ Do you have emotional support? __________

Who is in your household? ____

Do you have pets? ____

How would you describe your personality? ______________________________

What goals do you want to achieve in life? ______________________________

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