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Health Questionnaire

"If you do not ask the right questions you do not get the right answers. A question asked in the right way often points to its own answer. Asking questions is the A-B-C of diagnosis. Only the inquiring mind solves problems." Edward Hodnett

Date:_____ Referred by:_____ Pharmacy:_____ Internet

I. Personal Information

Name: _____ Age: _____

Birthplace: _____ Date of Birth: _____

Marital Status: ❑ Single ❑ Married ❑ Widow(er) ❑ Separated ❑ Divorced ❑ Partnered

Children: _____

Occupation: _____

Hobbies: _____

Pets: _____

Education: _____

What are your health goals? _____

_____

_____

II. General Health Information - *(Please bring copies of recent lab)*

Height:_____ Weight: _____ Blood Pressure: _____ When last taken: _____

When and where did you have your last physical checkup?_____

Name of family physician _____

Present illness / Main concern (**single** worst): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

List other concerns in order of severity: 1. _____

2. _____ 3. _____ 4. _____

Date or age main symptoms began? _____

Was there a trigger? _____

Began where? _____

How often do episodes occur? _____

How long do they last? _____

❑ Yes ❑ No Free of symptoms? When? _____

What factors do you know or suspect from your own experience cause your symptoms or make them worse? _____

_____

What makes your symptoms better? _____

_____

What kind of medical doctors or specialists have you seen for your main complaint?

_____

What was your diagnosis, what advice was given? _____

_____

Have you recently been treated by any of these types of practitioners?

❑ Yes	❑ No	Psychologist	❑ Yes	❑ No	Homeopath	❑ Yes	❑ No	Biofeedback
❑ Yes	❑ No	Osteopath	❑ Yes	❑ No	Acupuncturist	❑ Yes	❑ No	Naturopath
❑ Yes	❑ No	Chiropractor	❑ Yes	❑ No	Reflexologist	❑ Yes	❑ No	Nutritionist
❑ Yes	❑ No	Kinesiologist	❑ Yes	❑ No	Hypnotist			

Check Diagnostic Studies/Procedures you have had:

Biopsy: _____	Date: _____	Results: _____
Blood test(s): _____	Date: _____	Results: _____
_____	_____	_____
Cholesterol: _____	Date: _____	Results: _____
Body Scan(s): _____	Date: _____	Results: _____
Bone Density: _____	Date: _____	Results: _____
Colonoscopy: _____	Date: _____	Results: _____
Electrocardiogram: _____	Date: _____	Results: _____
Hearing Test: _____	Date: _____	Results: _____
Mammogram: _____	Date: _____	Results: _____
MRI: _____	Date: _____	Results: _____
PAP: _____	Date: _____	Results: _____
PSA: _____	Date: _____	Results: _____
X-rays: _____	Date: _____	Results: _____

Vaccines

Flu: _____	Date: _____	TB Test _____	Date: _____
Pneumonia: _____	Date: _____	Menningitis: _____	Date: _____
Shingles: _____	Date: _____		
Tetanus: _____	Date: _____		
HPV: _____	Date: _____		

Medications

	Name	Dose	Frequency	Duration
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Supplements/Vitamins

	Name	Dose	Frequency	Duration
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Allergy or Adverse Reactions *(Medications or supplements only)*

	Substance	Reaction
1		
2		
3		
4		
5		

Surgical History

	Surgery	Date	Reason for Surgery
1			
2			
3			
4			
5			

Immediate Family

Instructions: Please include all information you know of related to the following areas.

What is your ancestry / ethnicity? _____

					Paternal		Maternal	
	Father	Mother	Brother	Sister	Grandfather	Grandmother	Grandfather	Grandmother
Age if living								
Age at death								
Cause of death								
Type of work								
Asthma Allergy Hives Eczema								
Blood clots								
Weight problem								
Tobacco use								
Alcohol abuse								
Mental Illness								
Cancer								
Diabetes								
Hypertension								
Heart problem								
High cholesterol								
Thyroid disease								
Ulcers								
Arthritis								
Osteoporosis								
Other								

Ears, Nose, Throat

❑ Yes ❑ No Do you have ringing or buzzing in your ears?

❑ Yes ❑ No Do you have allergies? _____Chemical _____Seasonal _____Animals _____Dust _____Mold

❑ Yes ❑ No Do you have any nasal polyps?

❑ Yes ❑ No Have you had sinus infections? Within the last year? _____

❑ Yes ❑ No Hearing Aid?

❑ Yes ❑ No Do you have any decayed painful teeth or bleeding gums?

❑ Yes ❑ No Do you have persistent sores in your mouth?

❑ Yes ❑ No Do you have trouble swallowing foods?

❑ Yes ❑ No Do you often have hoarseness?

❑ Yes ❑ No Do you floss everyday?

❑ Yes ❑ No Do you have filling in your teeth? Which type? _____

Dermatologic

❑ Yes ❑ No Do you have a chronic skin condition?
❑ Yes ❑ No Do you tend to have dandruff?
❑ Yes ❑ No Fungus?
❑ Yes ❑ No Hair falling out?
❑ Yes ❑ No Do your nails split easily?

Eyes

❑ Yes ❑ No Dryness?
❑ Yes ❑ No Sensitive to light?
❑ Yes ❑ No Wear glasses or contacts?
❑ Yes ❑ No Glaucoma?
❑ Yes ❑ No Cataracts?
❑ Yes ❑ No Macular degeneration?
❑ Yes ❑ No Difficulty seeing at night?

Headaches

❑ Yes ❑ No Migraine?
❑ Yes ❑ No Sinus?
❑ Yes ❑ No Tension?

Check items associated with headache:

❑ Loss of sight
❑ Dazzling lights
❑ Diarrhea
❑ Tender or painful skin
❑ Tearing of eye
❑ Nasal drip
❑ Light sensitivity
❑ Visual disturbance
❑ Noise sensitivity
❑ Queasy stomach
❑ Abdominal pain
❑ Nausea
❑ Vomiting
❑ Neck / Shoulder pain
❑ Flushing
❑ Chilly sensation

Endocrine

❑ Yes ❑ No Do you have chronic fatigue?
❑ Yes ❑ No Do you have insomnia?
❑ Yes ❑ No Do you obtain 8 hours of sleep each night? If not, how much? _____
❑ Yes ❑ No Have you lost or gained more than ten pounds in the last year?
Lowest adult weight_____ Lbs _____ Age
Highest adult weight_____ Lbs _____ Age
❑ Yes ❑ No How much would you like to weigh? _____ Lbs
❑ Yes ❑ No Have you ever had thyroid trouble? Low? _____ High? _____
❑ Yes ❑ No Have you had hypoglycemia?
❑ Yes ❑ No Have you ever been diagnosed with metabolic syndrome or insulin resistance?

Hematology

❑ Yes ❑ No Have you had a low white blood count?
❑ Yes ❑ No Have you ever been anemic? (Had low red blood count.)
❑ Yes ❑ No Have you taken iron pills previously?
❑ Yes ❑ No Do you bruise easily?
❑ Yes ❑ No Have you noticed swelling lymph glands in your neck, armpits or groin lately?
❑ Yes ❑ No Have you had blood clots?

Chest Cardiovascular

❑ Yes ❑ No Have you had asthma? When? _____

❑ Yes ❑ No Have you ever been told you have emphysema or chronic bronchitis or another disease?

❑ Yes ❑ No Do you get out of breath easily?

❑ Yes ❑ No Do you have chest tightness?

❑ Yes ❑ No Have you recently had episodes of chest pain lasting more than one minute?

❑ Yes ❑ No Have you ever had a heart attack?

❑ Yes ❑ No Have you had an abnormal EKG?

❑ Yes ❑ No Does your heart race or skip?

❑ Yes ❑ No Have you had a heart murmur?

❑ Yes ❑ No Have you had swelling in your feet or ankles?

❑ Yes ❑ No Do you have high blood pressure?

How far can you walk vigorously before becoming short of breath? _____

Gastrointestinal

❑ Yes ❑ No Were you ever treated for ulcers?

❑ Yes ❑ No Have you had black bowel movements?

❑ Yes ❑ No Have you had blood in your stools, even in small amounts?

❑ Yes ❑ No Have you ever had yellow jaundice or hepatitis?

Check symptoms that apply:

❑ Heartburn
❑ Bloating
❑ Cramping
❑ Use laxatives
❑ Mucus in stools
❑ Nausea
❑ Indigestion
❑ Flatulence
❑ Queasy Stomach
❑ Diarrhea
❑ Gallbladder trouble
❑ Abdominal pain
❑ Belch frequently
❑ Stomach aches
❑ Constipation
❑ Anal itching
❑ Hemorrhoids

Urinary

❑ Yes ❑ No Do you usually have to get up at night to urinate? How many times? _____

❑ Yes ❑ No Do you void only small amounts of urine each time you go?

❑ Yes ❑ No Does it hurt to urinate?

❑ Yes ❑ No Do you lose urine when you cough or sneeze?

❑ Yes ❑ No Have you ever had kidney stones? What kind? _____

Sexually attracted to: ❑ Male ❑ Female ❑ Both

Neurology

❑ Yes ❑ No Have you had head injuries?

❑ Yes ❑ No Have you ever had blackout spells? If so, when? _____

❑ Yes ❑ No Have you ever had seizures (convulsions)? If so, when? _____

❑ Yes ❑ No Have you ever lost your ability to speak?

❑ Yes ❑ No Are there times when you have trouble thinking clearly or explaining what you mean?

❑ Yes ❑ No Were you ever told you had learning disabilities or dyslexia?

Skeletal

❑ Yes ❑ No Do you have arthritis? What kind? _____

❑ Yes ❑ No Do you have fibromyalgia?

❑ Yes ❑ No Do you have muscle spasms, pain, fatigue?

❑ Yes ❑ No Do you experience restless legs?

Women Only

Preimenopause/Menopause Symptoms

Check all symptoms you are currently experiencing:

❑ Hot flashes ❑ Irregular or absent menstrual cycles ❑ Lack of sexual desire/orgasm ❑ Memory loss

❑ Mood swings ❑ Night sweats ❑ Skin wrinkles ❑ Vaginal dryness ❑ Other _____

Sexual/Reproductive

First day of last menstrual period? _____

❑ Yes ❑ No Do you have heavy bleeding and/or painful menstrual cycles?

❑ Yes ❑ No Have you been diagnosed with PMS (Premenstrual Syndrome) or PMDD (Premenstrual Dysphonic Disorder?

❑ Yes ❑ No Have you been diagnosed with PCOS (Polycystic Ovarian Syndrome)

❑ Yes ❑ No Are you currently using contraception? If “yes,” what method? _____

❑ Yes ❑ No Are you trying to get pregnant?

❑ Yes ❑ No Have you had more than 1 miscarriage?

❑ Yes ❑ No Have you ever had a high risk pregnancy, premature delivery, or other complication of pregnancy/delivery?

Describe: _____

How many times have you been pregnant? _____

How much did your largest baby weigh? _____

❑ Yes ❑ No Are you currently sexually active?

❑ Yes ❑ No Is intercourse painful?

❑ Yes ❑ No Have you ever had an abnormal pap smear? If “yes”, when_____ Results_____

❑ Yes ❑ No Have you ever been diagnosed with Genital Herpes or HPV (Human Papilloma Virus)?

❑ Yes ❑ No Have you ever been treated for other sexually transmitted infections?

❑ Yes ❑ No Are you currently experiencing abnormal vaginal discharge?

❑ Yes ❑ No Are you experiencing low libido/lack of sexual desire?

Men Only

❑ Yes ❑ No Discharge from penis? Sores on penis?

❑ Yes ❑ No Lump or pain in testicle(s)?

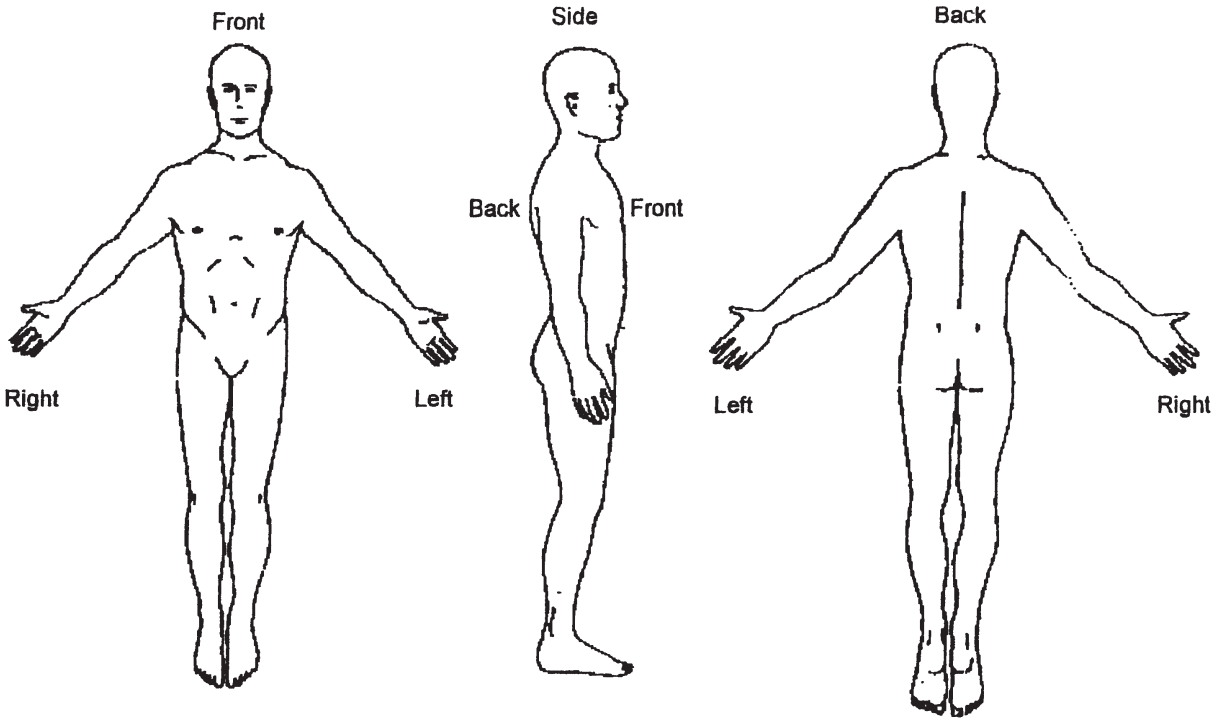
❑ Yes ❑ No Do you have a decrease in libido?

❑ Yes ❑ No Are your erections less strong?

❑ Yes ❑ No Inability to achieve or sustain an erection?

Headache, Nerve, Muscular or Skeletal Pain

❑ Yes ❑ No Please color on the picture where you have pain or other symptoms. Include symptoms of pain, numbness or tingling.



❑ Yes ❑ No Are there foods that make your symptoms better? Worse? Explain: _____

_____

_____

❑ Yes ❑ No Do you feel better if you skip a meal? _____

❑ Yes ❑ No Have you ever fasted? When? _____ For How Long? _____

❑ Yes ❑ No Are there foods you occasionally crave? Explain: _____

_____

If you could not eat for several days, what food or foods would you miss the most? _____

_____

Are most of your meals _____ at home _____ at restaurants

Please list what you typically eat for:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____ Beverages: _____

_____

_____

Personal Habits

Do you consider your health to be: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

How often do you exercise? ❑ At least 3 times a week ❑ Occasionally ❑ Rarely ❑ Never

If you exercise, what do you do? _____

For how long and how often? _____

Tobacco Use

❑ Yes ❑ No Do you currently smoke cigarettes?

If yes, how many per day? _____ When did you start? _____

If you do not currently smoke cigarettes, have you ever smoked? ❑ Yes ❑ No

If yes, when did you start? _____ How many per day? _____ When did you stop? _____

Do you use any other type of tobacco? ❑ Yes ❑ No If yes, what? _____

Alcohol and Drug Use

❑ Yes ❑ No Do you drink alcohol? If yes, how many drinks do you have each week? _____

❑ Yes ❑ No Do you ever have a drink in the morning to help you get going?

❑ Yes ❑ No Have you ever tried to cut down on your drinking?

❑ Yes ❑ No Have you ever felt guilty about the amount you drink?

❑ Yes ❑ No Have you ever been an alcoholic?

❑ Yes ❑ No Do you use recreational drugs?

Abuse

❑ Yes ❑ No Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

❑ Yes ❑ No Within the last year, has anyone ever forced you to have sexual activities?

❑ Yes ❑ No Do you feel you are verbally or emotionally abused by someone?

❑ Yes ❑ No Have you had counseling for these issues?

Stress Management

How do you handle stress? ❑ Very well ❑ Moderately well ❑ Poorly

Check all the stressors, if any, that apply to you:

❑ Family member(s) ❑ Financial ❑ Health issues ❑ Job/Professional Issues

What do you do to relax? _____

❑ Yes ❑ No Is your hostility easily aroused?

❑ Yes ❑ No Do you show aggressive impatience with anyone or anything that delays you?

❑ Yes ❑ No Do you get enough leisure time?

❑ Yes ❑ No Are you usually happy?

❑ Yes ❑ No Do you have too many responsibilities?

❑ Yes ❑ No Is your job satisfying to you?

❑ Yes ❑ No Is your job upsetting you?

❑ Yes ❑ No Are you usually satisfied with medical advice?

❑ Yes ❑ No Do you have periods of worry or feeling tense?

❑ Yes ❑ No Do you feel depressed or lonely?

❑ Yes ❑ No Do you have crying spells?

Health Maintenance

❑ Yes ❑ No Do you have carbon monoxide and smoke detectors in your home?
When did you last check the batteries? _____
❑ Yes ❑ No Do you wear seat belts ALL of the time?
❑ Yes ❑ No Do you talk or text on your cell phone while driving?
❑ Yes ❑ No Do you use sunscreen?
❑ Yes ❑ No Do you have an advanced directive, living will, and health care power of attorney?
How many hours per week do you spend?
Watching TV_____ Internet_____ Cell Phones/Texting_____
Computer other than work_____ Video Games/Movies _____

Thank you for the effort put into completing your health questionnaire!

"The secret of the care of the patient is in caring for the patient."
Francis Weld Peabody
1881-1927

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