Confidential Health History Questionnaire

Full Name:____

Date of Birth: _______/_______/_______ Age: _______ Birthplace:_______________

Home Address:____

Home phone:( ) __________Work phone:( ) __________Cell phone:( ) ____________

Gender: ( ) M ( ) F Height: ______'______" Weight: _________ lbs.

Occupation:____________________________ Employer: ______________________________

How many hours do you work per week?____

Emergency contact: _____________________ phone #: _______________________________

Primary Care Physician: ___________________________ phone #:________________________

OBGYN: _______________________________________ phone #:_______________________

How did you hear about my office? ____

Email address:____

I understand that I am responsible for full payment of professional services rendered to me

____Signature &date

LIST ALL YOUR CONDITIONS, STARTING WITH THE MOST IMPORTANT…

1. ____

How long have you had this: _______ days/weeks/months/years. Is this a flare up? Yes/No
How frequently do you experience this condition?: constant/daily/weekly/monthly/seasonally
What is the Intensity of your Discomfort: 1 – 10 (10 being most severe) : _____
Provide Name & phone # of who is currently treating you for this :_______________________
____

2. ____

How long have you had this: _______ days/weeks/months/years. Is this a flare up? Yes/No
How frequently do you experience this condition?: constant/daily/weekly/monthly/seasonally
What is the Intensity of your Discomfort: 1 – 10 (10 being most severe) : _____
Provide Name & phone # of who is currently treating you for this :_______________________
____

3. ____

How long have you had this: _______ days/weeks/months/years. Is this a flare up? Yes/No
How frequently do you experience this condition?: constant/daily/weekly/monthly/seasonally
What is the Intensity of your Discomfort: 1 – 10 (10 being most severe) : _____
Provide Name & phone # of who is currently treating you for this :_______________________
____

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Medical History:

RECENT TESTS: Please check any tests taken within last year and significant results:

( ) Physical	( ) Cholesterol	( ) Blood workup	( ) HIV/AIDS
( ) Thyroid	( ) Colonoscopy	( ) Stress Test	( ) Hepatitis A/B/C
( ) MRI	( ) X rays	( ) CAT scan	( ) Prostate
( ) Mammogram	( ) Pap smear	( ) Liver panel	( ) Other:

Significant results:

FAMILY HISTORY: Please read the following directions carefully:

CHECK any condition you had in the past. CIRCLE if you currently have the condition.

( ) Addiction:___________	( ) Ebstein Barr Virus, EBV	( ) Meningitis, viral/bacterial
( ) Allergies	( ) Emphysema	( ) Migraines
( ) Anxiety / Panic Attacks	( ) Epilepsy / Seizures	( ) Mononucleosis
( ) Asthma	( ) Eyes: glaucoma / cataracts	( ) Multiple Sclerosis, MS
( ) Arthritis	( ) Headaches: tension / cluster	( ) Osteoporosis
( ) Bursitis:_____________	( ) Heart Disease: heart attack	( ) Pneumonia
( ) Cancer: _____________	( ) Hepatitis A/B/C, chronic	( ) Polio
( ) Cancer: _____________	( ) High Blood Pressure	( ) Psoriasis / Eczema
( ) Chicken Pox	( ) High Cholesterol:_____	( ) Reflux / Ulcers
( ) Crohns / Colitis	( ) High fevers: _________	( ) Rheumatic Fever
( ) Chronic Fatigue	( ) HIV / AIDS	( ) STD: ______________
( ) Chronic Bronchitis	( ) Irritable Bowel	( ) Stroke
( ) COPD	( ) Jaundice	( ) Tendonitis
( ) Depression	( ) Leukemia:___________	( ) Thyroid: hypo / hyper
( ) Diabetes, Type I, II	( ) Lymes Disease	( ) Tinnitus: Hi / Low pitch
( ) Diverticulitis	( ) Lupus	( ) Tumor / Mass: ________
( ) Eating Disorder	( ) Measles / Mumps	( ) Turberculosis

CHECK IF FAMILY MEMBER HAS OR HAD THESE CONDITIONS:

	Heart Attack/Stroke	Cancer	High Blood Pressure	High Cholesterol	Depression
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Siblings	_____	_____	_____	_____	_____

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Please list ALL Medications & Supplements Dosage Taking for what condition

Please list ALL Medications & Supplements	Dosage	Taking for what condition
1.________________________________	__________	__________________________
2. _______________________________	__________	__________________________
3. _______________________________	__________	__________________________
4. _______________________________	__________	__________________________

Use back of paper if you need extra room. ____ *See back of paper (check if needed)*

Please list ALL known Allergies:

1. ____________________________________ 4. ______________________________

2. ____________________________________ 5. ______________________________

3. ____________________________________ 6. ______________________________

Please list ALL surgeries and/or Hospitalizations	Year	For what condition
1.___________________________________	_______	____________________
2. __________________________________	_______	____________________
3. __________________________________	_______	____________________
4. __________________________________	_______	____________________

Please list ALL emotional and physical traumas (death, move, divorce, birth, car accident)

1. ____ age:_______________

2. ____ age: _______________

3. ____ age: _______________

4. ____ age: _______________

Please CHECK areas where you experience pain and discomfort:

HEAD	( ) temples	( )forehead	( ) sinuses	( ) jaw	( ) back of head
TRUNK	( ) neck	( ) shoulders	( ) chest	( ) upper back	( ) mid-back
	( ) low back	( ) abdomen	( ) intestines	( ) hips	( ) pelvic/groin
ARMS	( ) upper arm	( ) elbows	( ) forearms	( )wrists	( ) hands & fingers
LEGS	( ) thighs	( ) knees	( ) calves	( ) ankles	( ) feet &toes

Is your pain or discomfort: ( ) Sharp ( ) Burning ( ) Aching ( ) Cramping
( ) Dull ( ) Fixed ( ) Moving ( ) Tight

What helps the pain? ( ) Cold ( ) Heat ( ) Exercise ( ) Rest

What makes the pain worse? ( ) Cold ( ) Heat ( ) Exercise ( ) Rest
( ) Pressure ( ) Humidity

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WOMEN ONLY: MENSTRUAL CYCLE: Please fill out following information:

Age of first menstruation (menarche): ________ Could you be pregnant? YES/NO

Days of Cycle (period to period): # ________ Type of Contraception: _____________

Average number of days you bleed: _________ Pregnancies: _____ Miscarriages: ______

Please describe your pregnancies (full-term, complications, vaginal births…):________________

CHECK if you have or had any of these conditions?

( ) irregular cycles ( ) pain between cycles ( ) endometriosis ( ) yeast infections

( ) D & C ( ) cervical dysplasia ( ) fibrocystic breasts ( ) ovarian cysts

( ) hysterectomy: partial or full ( ) pain during intercourse

Mark an "B" if symptom occurs Before your cycle begins, "D" if during, and "A" if after.

( ) anxiety ( ) breast swelling ( ) breast tenderness ( ) heavy bleeding

( ) breast lumps ( ) clots ( ) constipation ( ) scanty bleeding

( ) diarrhea ( ) depression ( ) food cravings ( ) vaginal discharge

( ) headaches ( ) irritability ( ) nausea ( ) spotting

( ) abdominal pain ( ) spotting ( ) fatigue

( ) sweating ( ) water retention ( ) vaginal discharge

Please fill in the following menstruation chart, even if you no longer have a cycle!!

	*Day 1	*Day 2	*Day 3	*Day 4	*Day 5	*Day 6	*Day 7
Color: (pale brown, pale red, bright red, brown, rust, dark, purple, other	* *	* *	* *	* *	* *	* *	* *
Amount of flow (normal, heavy, light, spotting	* *	* *	* *	* *	* *	* *	* *
Pain/cramps: (lower abdomen, ovaries, low back, groin	* *	* *	* *	* *	* *	* *	* *
Pain/cramps: Quality (dull, achy, sharp, stabbing, moving	* *	* *	* *	* *	* *	* *	* *
Clots: (dime size, nickel, quarter size) Color: (black, red, purple)	* *	* *	* *	* *	* *	* *	* *
Other symptoms: (v) vomiting, (N) nausea	* *	* *	* *	* *	* *	* *	* *

MEN ONLY: Please check if you are experiencing any of the following symptoms:

( ) Enlarged Prostate ( ) Impotence ( ) Premature ejaculation

( ) Testicular pain ( ) Low sperm count ( ) Low sex drive ( ) PSA:____

*Please remember to bring all medical records and your primary physician's information.

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Patient/Guardian Signature: ___________________Print Name: ________________

Please check the following if you have experienced it within the last 6-12 months. When given multiple symptoms on one line, circle all that apply. Be as thorough as possible.

Heart

( )**Heart disease:____________**

( ) Tendency to speak loudly and quickly
( ) Palpitations
( ) Anxiety
( ) Night sweats
( ) Ulcers/sores in the mouth or tongue
( ) Restlessness
( ) Difficulty staying asleep
( ) Mental confusion
( ) Chest pain, may travel to shoulder
( ) Frequent dreams
( ) Rash on the chest
( ) Wakes up unrefreshed
( ) Hot flashes
( ) Poor circulation
( ) Drink coffee (# cups per week _______)
( ) speech problems
( ) feeling of impeding doom

Lung

( ) **Lung disease: ___________________**

( ) Frequent colds/upper respiratory infections
( ) Nasal discharge (color _________)
( ) Cough
( ) Nose Bleeds
( ) Sinus Congestion
( ) Dry Mouth
( ) Dry Throat Dry Nose
( ) Dry Skin
( ) Skin tends to be itchy flaky
( ) Difficulty breathing: with inhaling with exhaling
( ) Allergies: seasonal/food/chemical: _____________
( ) I experience Grief and/or Sadness
( ) Shortness of Breath
( ) Sneezing
( ) Smoke cigarettes (# per day _____)
( ) perspire easily
( ) craves spicy foods

Small Intestine

( ) Bad Breath
( ) Heartburn
( ) burning urination
( ) lower abdominal pain

Large Intestine

( ) Constipation
( ) Dry stools
( ) BM: _____ x every _____ day
( ) Gas: no odor/ odor
( ) Diarrhea: no odor/ odor
( ) Undigested Food in Stools
( )Difficulty letting go of things
( ) Hemorrhoids
( ) Diverticulitis or Colitis
( ) Pain in lower abdomen
( ) Irritable Bowel Syndrome
( ) Crohn's Disease
( ) Blood in Stools
( ) Mucous in Stools

Spleen

( ) Poor short term memory
( ) Inability to concentrate
( ) Bruises easily
( ) Appetite High___ Low___
( ) Abdominal Bloating
( ) Fatigue after Eating
( ) Cravings for Sweet/Salty
( ) Overweight _____lbs.
( ) Loose Stools/diarrhea
( ) Prolapsed Organs: ___________
( ) Hemorrhoids
( ) Tendency to Worry
( ) Overthinking/Obsessive Thoughts
( ) Muscle Weakness

Dampness

( ) Tendency to gain weight in abdomen/buttocks
( ) General sensation of heaviness
( ) Foggy thinking
( ) Swollen hands/joints
( ) Swelling of the legs/arms/abdomen
( ) Chest congestion
( ) Snoring
( ) Nausea

Stomach

( ) Stomach Pain
( ) Belching/Hiccoughs
( ) Reflux/Heartburn
( ) Nausea/Vomitting

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( ) Bad Breath
( ) Excessive Appetite
( ) Excessive Thirst
( ) Bleeding, swollen or painful gums

Kidney

( ) Poor kidney function
( ) Ringing in ears: low/high pitch
( ) Memory problems
( ) Knees: Weak
( ) Knees: painful
( ) Low Back Pain
( ) Crave Salty foods
( ) Difficulty Conceiving (Infertility)
( ) Frequent Cavities
( ) Easily broken bones
( ) Excessive Hair Loss
( ) Dry thin hair
( ) Kidney stones
( ) Hearing Loss
( ) Libido: high/low
( ) Wake up during night to urinate: ____ x
( ) Lack of bladder control
( ) Fear
( ) Easily startled
( ) Hot flashes
( ) Perspires easily
( ) Night Sweats
( ) Menopausal
( ) Dry mouth with thirst
( ) Hot sensation in hands/feet/chest
( ) Sweaty hands/feet
( ) Hot Body temperature (sensation)
( ) Do not get a menstrual period
( ) Irregular menstruation
( ) Difficult to sweat/Do not sweat
( ) Cold hands/feet
( ) Cold body temperature (sensation)
( ) Bone loss: osteoporosis/osteopenia
( ) Thyroid disorder: hypo/hyper
( )Slow to heal

Bladder

( ) Urine color: dark/yellow/red/brown
( ) Amount of urine: excessive/small
( ) Tendency toward Bladder infections
( ) Cloudy urination
( ) Difficult to start to urinate
( ) Blood in urine
( ) Frequent urination: ____ x day
( ) Urinary incontinence
( ) Painful urination

( ) Overweight ______ lbs
( ) Difficulty getting out of bed
( ) Symptoms aggravated by humidity
( ) Fatigue

Liver

( ) Jaundice
( ) Liver disorder: hepatitis/high liver enzymes
( ) Alternating diarrhea-constipation
( ) Chest Pain
( ) Tight sensation in chest
( ) Bitter Taste in the mouth
( ) Irritability/Anger easily
( ) Experience Frustration frequently
( ) Depression
( ) Skin rashes :__________________________
( ) High-pitched ringing in ears
( ) Tendency to have headaches: stress related
( ) Seizures/convulsions
( ) Muscle twitching/cramping/spasms
( ) Numbness/Tingling
( ) High stress level
( ) Do not like change
( ) Feel like I have a Lump in my throat
( ) Brittle nails/pale nail beds
( ) Sexually transmitted disease
( ) Drink alcohol (# per week_____): kind:_________
( ) Eyes:Itchy Hot Dry Gritty Tearing sensitive to light
( ) Blurry Vision or other eye disorder: ________
( ) Near sighted or Far sighted

Gallbladder

( ) Hip pain/sciatica
( ) Gallstones
( ) Headache on sides of head
( ) Timidity/shyness
( ) Limited range of motion - hips
( ) Limited range of motion – neck, shoulder
( ) Waking too early and inability to fall back asleep
( ) Neck & shoulder tension
( ) Difficulty making decisions

Immune System & Circulation

( ) Low Energy/Fatigue
( ) Shortness of Breath
( ) Easily catch colds
( ) General weakness
( ) Sweating with little exertion
( ) Bruise easily
( ) Tendency toward anemia
( ) Pale complexion
( ) Dry hair dry skin
( ) Palpitation

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( ) Urgent urination
( ) Urinary incontinence
( ) Muscle tightness along the spine
( ) Difficulty bending foward
( ) Poor circulation
( ) Poor sleep
( ) Poor digestion
( ) Feel worse after exercise

If there is anything else you would like to add that I have not addressed please discuss here: