

Patient Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone # (home) _____ (work) _____

(cell) _____ E-mail: _____

E-mail: _____

Age: _____ Date of Birth: _____ Gender: _____

Married ___ Partner ___ Separated ___ Divorced ___ Widowed ___ Single ___

Occupation: _____ Hours per week: _____ Retired: _____

Name of Spouse/Parent _____

Person to contact in the event of an emergency _____

Relationship: _____

Phone numbers: _____

Most recent primary care information

Physician's Name: _____

Address: _____

Signature: _____

Date: _____

Patient Health History Questionnaire

What is your most important health concern/concerns?

How long have you had this concern or condition?

What do you believe is the cause?

Is your condition: (please check)

Getting worse

Constant

Worse in morning

Worse in evening

Interfering with work/school

Interfering with sleep

Interfere with movement/sleep

You have had this or a similar condition in the past

Please list additional health concerns:

When was your last visit to a doctor's office, medical clinic, or hospital, what was the reason?

Are you currently under the care of a medical specialist? Please explain.

Are you currently under the care or have you been treated by a naturopathic physician, homeopath, Chinese medicine practitioner? Please give names and dates of treatment.

What are your goals and expectations?

Please list medications, vitamins, and supplements that you currently take (prescription and over the counter)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you had any known adverse reactions to medications or medical procedures?

Do you have any allergies to foods, drugs, or other allergens in your environment? Please explain.

What hospitalizations or surgery have you had? Please explain and give dates.

What diagnostic imaging studies you have had:

Bone Density scan	CT Scan	Endoscopy
Electrocardiogram	Electroencephalogram	Laporoscopy
Mammogram	MRI	Ultrasound
X-ray	Other _____	

What immunizations have you had? Include international travel vaccinations.

Diphtheria, Tetanus	Haemophilus Influenza type B	Influeza
Diphtheria, Pertussis, Tetanus	Measles, Mumps, Rubella	Polio
Hepatitis A	Pneumococcal	-inactive
Hepatitis B	Tetanus (alone)	-oral
Varicella (chicken pox)	Other: _____	

Have you had any of the following childhood illnesses?

Diphtheria	German Measles	Measles
Mumps	Rheumatic fever	Scarlet fever

Strep throat

Other: _____

Family History

	Father	Mother	Sister	Brother	Child
Age (if living)	_____	_____	_____	_____	_____
Health (g=good) (p=poor)	_____	_____	_____	_____	_____
Age at death (If deceased)	_____	_____	_____	_____	_____
Check those applicable					
Alcoholism	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Autoimmune Disease	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____
Gallbladder Disease	_____	_____	_____	_____	_____
Gastrointestinal Disorder	_____	_____	_____	_____	_____
Glaucoma or Cataracts	_____	_____	_____	_____	_____
Goiter	_____	_____	_____	_____	_____
Gum Disease	_____	_____	_____	_____	_____
Hay Fever. Hives	_____	_____	_____	_____	_____
Headaches	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Heart Murmur	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Infertility	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Liver Disease	_____	_____	_____	_____	_____
Lung Disease	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Neurologic Disorder	_____	_____	_____	_____	_____
Pain, chronic	_____	_____	_____	_____	_____
Skin Disorder	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____
Urinary disorder	_____	_____	_____	_____	_____
Vascular disorder	_____	_____	_____	_____	_____

Review of Systems

Please check any condition that you currently experience

Blood and Periphera

Vascular

Anemia
Cold hands/feet
Easy bleeding/bruising
Thrombophlebitis
Varicose veins

Cardiovascular

Angina
Chest pain
Fainting
Heart disease
High blood pressure
High cholesterol
Murmurs
Palpitations, fluttering
Rheumatic fever
Swelling in ankles

Ears

Dizziness
Earache
Impaired hearing
Ringing, tinnitus
Wax, excessive

Endocrine

Fatigue
Heat or cold
Intolerance
Increasing hunger
Increasing thirst
Seasonal depression

Eyes

Blurriness
Cataracts
Diminished night vision
Double vision
Eye pain
Glasses or contacts
Glaucoma
Impaired vision
Dry eyes
Watery eyes

Retinal detachment

Spots in vision
sensitivity to light

Gastrointestinal

Abdominal pains, cramps
Alternating diarrhea
and constipation
Belching
Blood in stool
Bowel movements
How often per day or
week? _____
Bulimia
Change in appetite
Change in thirst
Constipation
Diarrhea
Fatigue after eating
Flatulence
Heartburn
Hemorrhoids
Jaundice (yellow skin)
Liver disease
Nausea
Pain in rectum
Painful stool
Parasites, diagnosed
Reflux
Spastic colon
Trouble swallowing
Vomiting
Vomiting blood

Head

Headaches
Migraines
Head injury
Jaw, TMJ problems
Jaw clicks
Vertigo

Immune

Chronic fatigue
Swollen glands, chronic
Infections, chronic

slow wound healing

Mental/Emotional

Anxiety, nervousness
Decreased memory
Depression
Difficulty concentrating
Mood swings
Treatment for mental/
emotional concerns

Mouth and Throat

Frequent sore throat
Sore tongue, lips
Gum problems
Metallic taste in mouth
Hoarseness
Dental cavities
Teeth grinding
Bad breath
Excess saliva

Musculoskeletal

Arthritis
Broken bones
Joint pain or stiffness
Lower back pain
Muscle spasms or
cramps
Muscle weakness
Osteoporosis,
diagnosed
Sciatica

Neck

Goiter
Lumps
Pain or stiffness
Swollen glands
Whiplash history

Neurologic

Fainting
 Loss of memory
 Muscle weakness
 Numbness or tingling
 Paralysis
 Seizures
 Tremor
 Vertigo or dizziness

Nose and Sinuses

Frequent colds
 Hay fever
 Nose bleeds
 Red nose
 Runny nose
 Sinus problems
 Stuffiness, congestion

Respiratory

Asthma
 Difficulty breathing
 Emphysema
 Pain on breathing
 Pneumonia
 Pleurisy
 Rib fracture
 Shortness of breath
 At night
 Lying down
 With exertion
 Spitting up blood
 Sputum
 Tuberculosis
 Wheezing

Skin

Rashes
 Eczema

Hives

Boils

Itching

Color change

Lumps

Night sweats

Cancer

Moles

Hair loss

Urinary

Bed wetting

Frequent infections

Inability to hold urine

Increased frequency

Kidney stones

Pain with urination

Retention tendency

Female Reproductive

Age menses began _____
 Duration of flow _____
 Cycle length _____
 Regular cycles? _____
 Age of last menses _____
 (if menopausal)
 # of pregnancies _____
 # of live births _____
 # of miscarriages _____
 # of pregnancy _____
 terminations _____
 Date of last PAP _____

Monthly self breast exams?

yes no

Sexual orientation:

Hetero

Lesbian

Bi

Please check all that apply

Abnormal PAP

Birth control

what type? _____

Bleeding btw. Cycles

Breast lumps

Breast pain

Cramping

Cervical dysplasia

Endometriosis

Heavy menstrual flow

Hormone replacement
therapy

Hysterectomy

oophorectomy

Menopausal symptoms

Nipple discharge

Ovarian cysts

Painful intercourse

Sexually tran. infection

PMS

Scanty menses

Low libido

Sexually active

Uterine fibroids

Vaginal discharge

Difficulty conceiving

Male Reproductive

Type birth control
 Ejaculatory concerns

Penile discharge
 Penile sores

Testicular masses
 Testicular pain

Fertility concerns
Hernia
Impotence

Prostate disease
Sexually active
Sexually trans. Infection

Sexual orientation
Hetero
Bi
Gay

Lifestyle

Please describe your typical food intake:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

Glasses of water daily _____
Cups of coffee daily _____
Cups of tea daily _____
Preferred flavors
Sweet
Salty
Bitter
Sour
Pungent
Spicy
Bland
Tobacco? _____

Soda drinker?
type and quantity _____
Alcohol intake & type _____
Specific diet (check all that apply)
Atkins
Macrobiotic
Ovo-lacto vegetarian
Vegan
Raw foods
Whole foods
Blood type diet
Weight reduction plan
Zone
Other: _____

Energy level (1-10) _____
(10 = highest)
Warm or cool body temp _____
Quality of sleep _____
Hours of sleep _____
Stress level (1-10) _____
Hours work/week _____
Job satisfaction? _____
Support network? _____
Stable Relationship? _____

Exercise: _____
Spiritual practice: _____
Hobbies and interests: _____
Predominant emotions: _____