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HEALTH HISTORY QUESTIONNAIRE FOR ADULTS

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: ______________________ **Date of Birth:** _____/_____ /________ **Sex:** ___________

YOUR CARE TEAM		
Primary Care Physician:		**Phone #:**
Other Healthcare Practitioners *(Acupuncturist, massage therapist, counselor, specialist, yoga therapist, etc.)*		
Practitioner Name:	**Type of Practice:**	**Phone #:**
Have you seen a Naturopath before? ☐ No ☐ Yes; Who?		

HEALTH CONCERNS & GOALS	
Concern:	Date of Onset:
1.	
2.	
3.	
4.	
What is your goal for today's visit?	
Rate the following on a scale of 1-10; (1=least/poor 10=most/best)	
Energy 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	**Stress** 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Motivation 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	**Health** 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

MEDICATIONS & SUPPLEMENTS			
Prescription and OTC Medications	**Dosages**	**Vitamins, supplements, herbs, homeopathics**	**Dosages**

PAST MEDICAL HISTORY	
Known allergies/sensitivities	**Reactions (anaphylactic, hives, vomiting, etc…)**
Foods:	
Environmental:	
Medications:	
Are you sensitive to: ☐ Sugar ☐ Caffeine ☐ Chemicals ☐ Perfumes ☐ Medications	

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PAST MEDICAL HISTORY ***Continued***	
Previous health conditions and date diagnosed	**Previous surgeries and hospitalizations**
1.	1.
2.	2.
3.	3.
4.	4.

Date of last physical:	**Dental exam:**	**Mammogram:**
Blood test:	**Colonoscopy:**	**Bone density scan:**

PERSONAL HEALTH HABITS & OCCUPATIONAL HAZARDS		
Sleep	☐ Difficulty falling asleep ☐ Sleep uninterrupted through night ☐ Wake refreshed ☐ Take sleep aids ____________ ☐ Average hours of sleep per night________	
Exercise	Do you have physical activity in your life? ☐ No ☐ Yes → Describe:	
Diet	Do you exclude foods from your diet? ☐ No ☐ Yes → Describe: *Please give an example of what you eat on a typical day:* Breakfast: ____________ Lunch: ____________ Dinner: ____________ Snacks: ____________ Desserts: ____________ Beverages: ____________ Daily water intake: ____________ Do you eat organic foods: ☐ Always ☐ Often ☐ Sometimes ☐ Never	
Alcohol Consumption	☐ No ☐ Yes → Describe type, amount and frequency:	☐ Past Consumption Year Quit:
Recreational Drug Use	☐ No ☐ Yes → Describe type, amount and frequency:	☐ Past Use Year Quit:
Tobacco use	☐ No ☐ Yes → Describe type, amount and frequency:	☐ Past Use Year Quit:
Caffeine Consumption	☐ No ☐ Yes → Describe type, amount and frequency:	☐ Past Consumption Year Quit:
Occupational	Does your work expose you to the following: ☐ Stress ☐ Heavy Lifting ☐ Computer ☐ Hazardous Substances ☐ Other:	

SOCIAL HISTORY	
Occupation:	Highest level of education:
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partnership ☐ Other:	

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FAMILY MEDICAL HISTORY

Please fill in any health conditions for the following biological relatives.
If they are deceased, please include age and cause of death.

Mother:	Father:
Maternal Grandmother:	Paternal Grandmother:
Maternal Grandfather:	Paternal Grandfather:
Maternal Aunts/Uncles:	Paternal Aunts/Uncles:

Brother/Sister:	Brother/Sister:	Brother/Sister:

Family history is unknown: ☐ Adopted ☐ Other → Describe:

REVIEW OF SYSTEMS

Check any of the following symptoms that you have experienced in the last 3 months and record how frequently you have had them

General
- □ Fatigue/low energy
- □ Insomnia
- □ Appetite changes
- □ Unexplained weight loss/gain
- □ Fevers or chills
- □ Cold intolerance
- □ Heat intolerance
- □ Hot flashes
- □ Night sweats
- □ Sweat too much

Head
- □ Headaches
- □ Migraines
- □ Dizziness/Fainting
- □ Head Injury

Ears
- □ Ear pain
- □ Ear drainage/wax
- □ Ringing in ears
- □ Changes in hearing
- □ Hearing loss
- □ Use hearing aid

Nose
- □ Congestion
- □ Seasonal allergies/hay fever
- □ Post nasal drip
- □ Nosebleeds
- □ Sinus infections
- □ Loss of smell/taste

Eyes
- □ Corrective eyewear
- □ Dry/Itchy eyes
- □ Blurred vision
- □ Eyes water excessively
- □ Eyes sensitive to light
- □ Eyes puffy or bloodshot
- □ Night blindness
- □ Glaucoma
- □ Cataracts

Skin
- □ Rash
- □ Hives
- □ Eczema/Psoriasis
- □ Acne
- □ Dry skin
- □ Itchy skin
- □ Dandruff
- □ Warts/Moles
- □ Skin cancer
- □ Hair loss/thinning
- □ Weak nails/splitting nails
- □ Cuts heal slowly
- □ Athlete's foot

Neck
- □ Neck pain/stiffness
- □ Difficulty swallowing
- □ Swollen glands
- □ Lumps

Mouth/Throat
- □ Dry mouth/lips
- □ Sore throat/tonsillitis
- □ Hoarseness
- □ Bad breath
- □ Gum disease
- □ Cold sores/canker sores
- □ Loss of taste
- □ Metallic or bitter taste in mouth
- □ Teeth grinding
- □ Cavities
- □ Dentures

Cardiovascular
- □ High blood pressure
- □ Low blood pressure
- □ Fast heart beat
- □ Irregular heart beat
- □ Chest pain/tightness
- □ Palpitations
- □ Murmur
- □ Dizziness upon standing
- □ Swollen feet/ankles (edema)
- □ Hands/feet or fingernails turn blue
- □ Anemia

Respiratory
- □ Cough frequently
- □ Wheezing
- □ Shortness of breath
- □ Coughing up mucous or blood
- □ Asthma

Respiratory
- □ Bronchitis
- □ Frequent respiratory infections
- □ Tuberculosis

Gastrointestinal
- □ Food cravings
- □ Eating disorder
- □ Abdominal pain/tenderness
- □ Nausea/Vomiting
- □ Gas/Bloating
- □ Heartburn
- □ Ulcers
- □ Diarrhea
- □ Constipation
- □ Irritable bowel
- □ Dark or bloody stools
- □ Grey/yellow greasy stools
- □ Undigested foods in stools
- □ Foul odor to stool/gas
- □ Feeling of incomplete bowel movement
- □ Hemorrhoids
- □ Gallbladder disease
- □ Gallbladder stones
- □ Liver disease
- □ Number of bowel movements daily: _______

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<table>
<tr><th colspan="4">REVIEW OF SYSTEMS CONTINUED</th></tr>
<tr>
<td><u>Musculoskeletal</u>
□ Muscle pain/spasm
→ Describe: ____________
____
□ Swollen/painful joints
→ Describe: ____________
____
□ Leg pain/cramping
□ Muscle weakness
□ Broken/fractured bones
→ Describe: ____________
____________________</td>
<td><u>Neurological</u>
□ Numbness/tingling
□ Fainting/dizziness
□ Nerve pain
□ Tremors Twitching
□ Seizures/Convulsions</td>
<td><u>Psychological</u>
□ Anxiety
□ Anger/Irritability
□ Mood swings
□ Brain fog
□ Poor memory
□ Difficulty focusing
□ Depression
□ Fear/panic
□ Increased stress
□ Suicidal thoughts</td>
<td><u>Genital/Urinary</u>
□ Difficulty urinating
□ Painful urination
□ Incomplete Urination
□ Dribbling
□ Frequent urination
□ Frequent urination at night
□ Urgency
□ Discharge/blood in urine
□ Urinary tract infections
□ Incontinence
□ Kidney stones</td>
</tr>
<tr><th colspan="2">Female only</th><th>Male & Female</th><th>Male only</th></tr>
<tr>
<td>_____Age period began
_____Last menstrual period
_____Length of period (days)
_____How often period occurs
Y/N Cycle regular?
_____# Pregnancies
_____# Births
_____# Abortions
_____# Miscarriages
□ Heavy bleeding
□ Menstrual pain
□ PMS
□ Vaginal discharge
□ Vaginal dryness
□ Menopausal symptoms
□ Hot flashes
□ Night sweats
□ Insomnia</td>
<td>Date of Last PAP _________
□ Abnormal PAP
→ When? ______________
→ Treatment? __________
____
□ Hysterectomy
→ When? ______________
→ Why? _______________
____
□ Full or □ partial?
□ Hormone replacement therapy?
→ Birth control history
____
____
____
____________________</td>
<td><u>Breasts/Chest</u>
□ Do you do self breast exams?
□ Breast pain/tenderness
□ Nipple discharge
□ Lumps
□ Breast implants
□ Chest implants
□ Breast cancer
<u>Sexual history</u>
□ Sexually active
□ Current
□ Past
□ History of STI
→ Describe: __________
____
____
□ Healthy libido</td>
<td>□ Discharge from penis
□ Testicular pain/swelling
□ Erectile dysfunction
□ Infertility
□ Prostate disease

Date of last testicular/prostate exam:
____

Date of last PSA blood test:
____________________</td>
</tr>
</table>

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my health status. I also authorize the healthcare staff to perform the necessary health care services needed.

____ ____________________

Signature of patient or patient representative Date

____

Print Name