

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____

DATE OF LAST PHYSICAL EXAM: _____

Please list your worst symptoms in order of severity/importance:

- 1) _____ Date first experienced: _____
- 2) _____ Date first experienced: _____
- 3) _____ Date first experienced: _____
- 4) _____ Date first experienced: _____

What (if any) care did you seek in the past for the above? _____

What was the outcome of the care you had? _____

Are you currently receiving any treatments for the above conditions? YES NO

If yes, please describe: _____

What experiences have you had with Complementary - Nutritional medicine in the past?

What is your personal goal at our Center? _____

PAST MEDICAL HISTORY: Please indicate approximate date for all those that apply

Abnormal chest x-ray	___	Duodenal Ulcer	___	Hypoglycemia	___
Abnormal EKG	___	Dysentery	___	Impotence	___
Allergies	___	Ear Infections	___	Irritable Bowel Syndrome	___
Alzheimer's	___	Emotional Problems	___	Kidney Disease	___
Anemia	___	Emphysema	___	Melanoma	___
Angina	___	Endometriosis	___	Menopause	___
Anxiety Disorder	___	Epilepsy	___	Migraine Headaches	___
Arthritis	___	Fibroids	___	Multiple Sclerosis	___
Asthma	___	Gall Bladder Disease	___	Osteoporosis	___
Bleeding Disorder	___	Glaucoma	___	Overactive Thyroid	___
Blindness	___	Goiter	___	Panic Attacks	___
Blood clot	___	Gonorrhea	___	Phlebitis	___
Breast Disease	___	Gout	___	Premenstrual Syndrome	___
Broken Bone(s)	___	Hay Fever	___	Prostate Enlargement	___
Cancer	___	Heart Disease	___	Polio	___
Type: _____		Heart Murmur	___	Raynaud's	___
Carpal Tunnel Syndrome	___	Hemorrhoids	___	Skin Cancer	___
Cataract(s)	___	Hepatitis	___	Syphillis	___
Depression	___	Type: _____		Tuberculosis	___
Diabetes	___	Herpes	___	Underactive thyroid	___
Insulin Dependent?	___	Type: _____		OTHER: _____	
Diarrhea (chronic)	___	High Blood Pressure	___	_____	
Diverticulitis	___	High Cholesterol	___	_____	
Diverticulosis	___			_____	

PAST SURGICAL HISTORY: List all previous surgeries and dates _____

CURRENT MEDICATIONS: List all prescribed medications and dosages _____

OVER THE COUNTER MEDICATIONS (non-prescription) _____

CURRENT SUPPLEMENTS & VITAMINS: _____

ASSISTIVE DEVICES: Please circle all that apply: Hearing aid Contacts/Dentures
 Cane Pacemaker Walker Leg Brace Wheelchair Neck Brace Back Brace

IMMUNIZATIONS: Please circle all that you have received: Polio Tetanus Measles
 Rubella (German measles) Mumps Hepatitis B Flu Lyme OTHER: _____

ALLERGIES:

Drug Allergies: Are you aware of any drug (medication) allergies? Yes ____ No ____

If yes, please list all drug allergies: _____

Environmental / Inhaled Allergies: Please circle all that apply: Grass Tree Pollen Mold
Chemicals Perfumes Dyes Animals Insect Bites Dust Fumes Cosmetics
Latex Adhesives OTHER: _____

Food Allergies: Please circle all that apply: Eggs Dairy Wheat Soy Shellfish
OTHER: _____

HEALTH SCREENING EXAMS: Please indicate approximate date of tests you have had

Chest x-ray _____ Sonogram _____ Mammogram _____
EKG _____ Organ: _____ Pap Smear _____
Stress Test _____ CAT Scan _____ Cervical Biopsy _____
Echocardiogram _____ Organ: _____ Pelvic Sonogram _____
Pulmonary Function _____ MRI _____ Digital Rectal Exam _____
Organ: _____ PSA Blood Level _____
Prostate Biopsy _____

Please describe any abnormal findings: _____

OB / GYN HISTORY (for women):

Age at first period: _____ Description of cycles: Regular Irregular Absent
Approximate length of cycle (days between periods): _____ days. Length of period _____ days.
Description of menstrual flow: Heavy Medium Light Date of last menstrual period: _____

How many times have you been pregnant: _____ Number of live births: _____ Number of miscarriages: _____
Number of abortions: _____ Age at first pregnancy: _____

What method of birth control do you use? _____

Have you ever taken the birth control pill? YES NO ; If YES, when and for how long _____

Have you ever been on Hormone Replacement Therapy? YES NO ; If YES, when, for how long, and what type: _____

Have you ever experienced frequent vaginal infections? YES NO ; If YES, please describe: _____

FAMILY HISTORY:

Mother: Living, age _____ Deceased, at what age _____ Ethnicity _____
Major illness: _____ Cause of death _____

Father: Living; age _____ Deceased; at what age _____ Ethnicity _____
Major illness: _____ Cause of death _____

Maternal Family History: Major illnesses: _____

Paternal Family History: Major illnesses: _____

How many siblings do you have? _____ # Brothers _____ # Sisters _____

What number (birth order) are you? _____ Are all siblings living? YES NO

FAMILY HISTORY (Continued):

If LIVING, do any of them have any medical problems? _____

If DECEASED, what was the cause of death? _____

How many children do you have? _____ #Sons _____ # Daughters _____ #Living _____ #Deceased _____

Please give ages of LIVING children and any known medical problems: _____

Please give ages of DECEASED children and cause of death _____

To the best of your knowledge, having any of your blood relatives been diagnosed with the following (please circle and indicate which relative):

Alcoholism _____

Birth Defect _____

Epilepsy _____

Allergies _____

Bleeding Disorder _____

Heart Disease _____

Alzheimer's _____

Cancer _____

High Blood Pressure _____

Anemia _____

Depression _____

Kidney Disease _____

Asthma _____

Diabetes _____

Stroke _____

OTHER: _____

SOCIAL HISTORY:

Birth weight: _____ Place of Birth: _____ Trauma at Birth: _____ Breast Fed: YES NO

Tobacco: YES NO ; Type: _____ How many per day _____ How many years _____ Currently YES NO

Alcohol: YES NO ; Type: _____ Amount Weekly _____ How many years _____ Currently YES NO

Recreational Drugs: YES NO ; Type _____ Frequency _____ How many years _____

Currently YES NO

Marital Status: Single Married Divorced Separated Widow(er)

Residence: Private home Apartment College dorm Condo

Do you live: ALONE or WITH Spouse & Children Spouse Roommate Significant Other

How many years of education completed: High school: _____ College: _____ Graduate School: _____

What is your occupation? _____ How many hours per week do you work: _____

Do you exercise regularly? YES NO ; If YES, how often and type of exercise: _____

What are your hobbies? _____ Do you do volunteer work? _____

Do you sleep well? YES NO ; How many hours per night? _____

How is your energy level? _____ Do you have dental fillings or root canals? _____

Bowel Habits: Normal, how many per day? _____ Diarrhea _____ Tendency to constipation _____

Have you traveled outside of the United States? YES NO ; Any illness related to travel: _____

Do you have any pets in your home (past and present); what kind? _____

NUTRITIONAL HISTORY:

DO YOU eat organic? YES NO SOMETIMES Eat free range meats? YES NO SOMETIMES

Drink filtered/bottled water? YES NO SOMETIMES

Are you a vegetarian? YES NO If YES, what type? _____

