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Comprehensive Patient Health History Questionnaire

Holistic and preventative medicine is best accomplished when the doctor has a thorough understanding of the patient's physical, mental and emotional condition. The information on this questionnaire will help the doctor understand your needs and how to help you reach your health goals.
Please print all information and put a question mark by anything that you don't understand.
Thank you for taking the time and effort to complete this form.

What are your most important health concerns? List as many as you can in order of importance.

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

When did you last go to the doctor's office, medical clinic or hospital? What was the reason? _____

_____

FAMILY HISTORY

Check those applicable:	Father	Mother	Brother(s)	Sister(s)	Spouse	Child
Age						
Health (G=good P=poor)						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, Hayfever, Hives						
Kidney Disease						
Glaucoma						
Tuberculosis						
Age (at death)						
Cause of death						

Occupation: _____ Children: Yes ___ No ___ How many: _____

Marital Status: Single _____ Married _____ Divorced _____ Other _____

Do you live with: Spouse ___ Partner ___ Friends ___ Parents ___ Alone ___ Children ___

Childhood immunizations and vaccines:

Polio	Yes	No	Diphtheria	Yes	No	Tetanus shot		Yes	No	
Pertussis	Yes	No	Measles/Mumps/Rubella	Yes	No	Other		Yes	No	

Childhood illnesses:
Scarlet Fever Yes No Diphtheria Yes No Rheumatic Fever Yes No
Mumps Yes No Measles Yes No German Measles Yes No
Other _____

What Hospitalizations and Surgeries have you had? _____
_____

How many X-Ray, CAT, MRI, Ultrasound, Electrocardiogram, Electroencephalogram have you had? _____

_____

_____

Allergies:
Do you have any reaction to foods, drugs or other allergens in your environment (cats, mold, dust)?
Yes _____ No _____ If yes, please explain. _____
_____

Current Medications (Circle the medications that you take):
Pain relievers (aspirin or Tylenol) Cortisone (cream or pills) Thyroid medication Sleeping Pills
Diet Pills/Appetite suppressants Antacids (Rolaids or Tums) Tranquilizers

Please list any prescription medications, over-the-counter drugs, vitamins, minerals, herbs and other supplements that you are taking at this time and how much of these with doses.

1) _____ 4) _____ 7) _____
2) _____ 5) _____ 8) _____
3) _____ 6) _____ 9) _____

REVIEW OF SYMPTOMS

C = a current condition. P = a condition you have had in the past. N = a condition you have never had.

GENERAL			
Weight	_____		
Weight 1 year ago	_____		
Maximum weight	_____		
When	_____		
Height	_____		
Fatigue	C	P	N

SKIN			
Rashes	C	P	N
Eczema, Hives	C	P	N
Acne, Boils	C	P	N
Itching	C	P	N
Color change	C	P	N
Lumps	C	P	N
Night Sweats	C	P	N

NECK			
Lumps	C	P	N
Swollen glands	C	P	N
Goiter	C	P	N
Pain or stiffness	C	P	N

RESPIRATORY			
Cough	C	P	N
Sputum	C	P	N
Spitting up blood	C	P	N
Wheezing	C	P	N
Asthma	C	P	N
Bronchitis	C	P	N
Pneumonia	C	P	N
Pleurisy	C	P	N
Emphysema	C	P	N
Difficulty breathing	C	P	N

HEAD
Headache C P N
Head injury C P N

EYES
Impaired vision C P N
Glasses / Contacts C P N
Eye pain C P N
Tearing or Drying C P N
Double vision C P N
Glaucoma C P N
Cataracts C P N

EARS
Impaired hearing C P N
Ringing C P N
Dizziness C P N
Earache C P N
Vertigo C P N

NOSE and SINUS
Frequent colds C P N
Nose bleeds C P N
Stuffiness C P N
Hay fever C P N
Sinus problems C P N

MOUTH and THROAT
Frequent sore throat C P N
Sore tongue C P N
Gum problems C P N
Hoarseness C P N
Dental cavities C P N
Dental amalgams – how many? _____
Crowns? _____

FEMALE REPRODUCTIVE
Age menses began _____
Average number of days_____
Length of cycle _____
Bleeding between periods C P N
Are cycles regular C P N
Painful menses C P N
Painful during intercourse C P N
Excessive flow C P N
Birth control? Yes No
What type? _____
Number of pregnancies_____
Number of live births _____

Shortness of breath C P N
" at night C P N
" lying down C P N
Tuberculosis C P N

CARDIOVASCULAR
Heart disease C P N
Angina C P N
High blood pressure C P N
Murmurs C P N
Rheumatic fever C P N
Chest pain C P N
Swelling in ankles C P N
Palpitations, fluttering C P N

GASTROINTESTINAL
Trouble swallowing C P N
Heartburn C P N
Change in thirst C P N
Change in appetite C P N
Nausea C P N
Vomiting C P N
Vomiting blood C P N
Bowel movements
How often? _____
Is this a change? _____
Blood in stool C P N
Belching or passing gas C P N

Jaundice C P N
Liver disease C P N
Gall bladder disease C P N
Ulcer C P N
Hemorrhoids C P N

URINARY
Pain on urination C P N
Increased frequency C P N
Frequency at night C P N
Inability to hold urine C P N
Frequent infections C P N
Kidney stones C P N

EMOTIONAL
Depression C P N
Mood swings C P N
Anxiety or nervousness C P N
Tension C P N

ENDOCRINE
Hypothyroid C P N
Heat or cold intolerance C P N
Excessive thirst C P N
Excessive hunger C P N

Number of miscarriages_____
Number of abortions _____
Difficulty conceiving? Yes No
Menopausal symptoms C P N
Are you sexually active Yes No
Sexual difficulties C P N
Venereal disease C P N
Sexual preference:
Heterosexual _____
Bisexual _____
Homosexual _____
Do you do self-exam? C P N
Lumps C P N
Pain or tenderness C P N
Nipple discharge C P N

MALE REPRODUCTIVE
Hernias C P N
Testicular mass C P N
Testicular pain C P N
Are you sexually active? Yes No
Sexual difficulties C P N
Prostate disease C P N
Venereal disease C P N
Discharges or sores C P N
Sexual preference:
Heterosexual _____
Bisexual _____
Homosexual _____

MUSCULOSKELETAL
Joint pain or stiffness C P N
Arthritis C P N
Broken bones C P N
Muscle spasms or cramps C P N
Weakness C P N

PERIPHERAL VASCULAR
Deep leg pain C P N
Thrombophlebitis C P N
Cold hands/feet C P N
Varicose veins C P N

BLOOD
Anemia C P N
Easy bleeding or bruising C P N

What are your main interests and hobbies?
_____
_____

Do you exercise? Yes No
What type of exercise do you do?
_____
_____
How many days a week (0-7)?_____

Do you eat three meals a day? Yes No
Sleep well? Yes No

Average 6-8 hrs sleep? Yes No
Enjoy your work? Yes No
Spend time outside? Yes No
Watch television? Yes No
How many hours a day? _____
Read? How many hours a day?_____

Take vacations? Yes No
Have you been treated for drug dependence? Yes No
Use recreational drugs? Yes No
Use alcoholic beverages? Yes No
Have you been treated for alcoholism? Yes No
Use tobacco Yes No

NEUROLOGIC
Fainting C P N
Seizures C P N
Paralysis C P N
Muscle weakness C P N
Numbness or tingling C P N

_____ _____
Patient's signature Date of signature