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) ______________________________________

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

______________________________________________________________________________________

Childhood immunizations and vaccines:
Polio       Yes     No          Diphtheria       Yes     No          Tetanus shot     Yes     No
Pertussis   Yes     No          Measles/Mumps/Rubella Yes     No
Other ___________________________________________________________________________________

Hospitalizations and/or Surgeries? ______________________________________________________________

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:
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) ______________________  2) ___________________________  3) _____________________

Were there any problems during pregnancy or birth (ie drug or alcohol addition, severe stress, premature birth, C-section etc.)? ____________________________________________________________

Weight and Height? _____________________________________________________________
Review of Symptoms
Check line if any symptoms are current or in the past noteworthy

**SKIN & NECK**
- Rashes
- Swollen Glands
- Eczema, Hives
- Night Sweats

**RESPIRATORY**
- Cough
- Asthma
- Pneumonia
- Difficulty breathing
- Spitting up blood
- Bronchitis

**EYES**
- Impaired vision
- Glasses / Contacts
- Plugged Tear duct

**CARDIOVASCULAR**
- High blood pressure
- Murmurs

**EARS**
- Impaired hearing
- Ringing
- Earache

**GASTROINTESTINAL**
- Trouble Swallowing
- Nausea
- Vomiting blood
- Bowel Movements how often?
- Reflux
- Burping or gas
- Is this a change?

**NOSE and SINUS**
- Frequent colds
- Hay fever
- Sinus problems
- Stuffiness
- Sinus problems

**MOUTH and THROAT**
- Frequent sore throat
- Gum problems

**URINARY**
- Pain on urination
- Frequent infections

**FEMALE REPRODUCTIVE**
- Age menses began
- Average number of days
- Painful menses
- Bleeding between periods

**MALE REPRODUCTIVE**
- Circumcised
- Descended Testes

**SLEEP**
- How long does child sleep in the night?
- How often does child wake up?
- Does your child nap and for how long?
- Does anyone in the household Smoke?
- Pets? How Many?
- New Construction in the home?
- Mold in home?
- Do you read bedtime stories to your child? Yes/No
- Does your family eat meals together? Yes/No
- Foreign Travel?
- TV/Computer use – How long?

Patient’s signature ________________________________ Date of signature ________________________________

Child Health History Questionnaire