Clinic use only: Dr:_______________ Leave message at: Cell Home Work

Date __________________ Name you prefer to be called _______________________________________
First Name ____________________ Middle __________________ Last __________________________
Date of Birth ________________ Age _____ Sex ***(circle one):*** **F M F to M M to F**
Address ____
City ________________________________ State __________________ Zip Code __________
Cell Phone (_____)__________________ Work Phone (_____)________________
Home Phone (_____)__________________ Other Phone (_____)________________
Best contact number? **Cell Work Home Other** Best number to leave a message? **C W H O**
E-mail Address: ____ May we contact you by email? **Y N**

Occupation ___________________________ Hours per week ________ Retired **Y N**
Employer ____________________________ Location ___________________________________

What is your relationship status? ***(Please circle one)***:
Single Married Significant Partner Separated Divorced Widowed

Do you live with: ***(Please circle all that apply):***
Alone Spouse/Partner Child(ren) Parent(s) Relative(s) Friend(s) Roommate(s)

Emergency contact ____________________________________Relationship ______________________
Phone __________________or ____________________ Location (city, state) ______________________

I am willing to let my medical records be used anonymously for research purposes. **Y N**

HISTORY QUESTIONNAIRE

Holistic health care and preventive medicine are only possible when the physician has complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. ***Print all information; mark anything you don't understand with a question mark.***

When did you last receive medical/health care? ____
Where? ____
For what reason? ____
What are your most important health issues? List as many as you can in order of importance:
1) _____________________________________ 4) ______________________________________
2) _____________________________________ 5) ______________________________________
3) _____________________________________ 6) ______________________________________

How did you hear about us? *(Please check if applicable)*
Medical Referral____ Friend____Who?_____________________________TV____Radio___
Yellow Pages____Internet____ Ads____Which one?______________ Other__________________

Family History: Please check applicable conditions for each family member.

	Father	Mother	Brother	Sister	Child	Spouse/Partner
Age (if living, or at death)	______	______	______	______	______	______
(If deceased) Cause	______	______	______	______	______	______
Health: G=Good P=Poor	______	______	______	______	______	______
Cancer (Type?)	______	______	______	______	______	______
Diabetes	______	______	______	______	______	______
Heart Disease	______	______	______	______	______	______
High Blood Pressure	______	______	______	______	______	______
Alzheimer's	______	______	______	______	______	______
Stroke	______	______	______	______	______	______
Epilepsy	______	______	______	______	______	______
Mental Illness	______	______	______	______	______	______
Kidney Disease	______	______	______	______	______	______
Glaucoma	______	______	______	______	______	______
Osteoporosis	______	______	______	______	______	______
Tuberculosis	______	______	______	______	______	______
Other	______	______	______	______	______	______

For the following sections, please circle Y=Yes or N=No

Childhood Illnesses:

Scarlet fever **Y N** Diphtheria **Y N** Rheumatic Fever **Y N** German Measles **Y N**
Mumps **Y N** Measles **Y N** Other ____

Hospitalization and Surgery: Hospitalizations or surgeries you have had and when:

____

X-rays and Special Studies: X-rays, CAT scans, or MRI's you have had and when:

____

Electrocardiogram (EKG) **Y N** Electroencephalogram (EEG) **Y N**

Immunizations:

Polio **Y N** Tetanus Shot (not antitoxin) **Y N** Diphtheria **Y N**
Pertussis **Y N** Measles/Mumps/Rubella **Y N** Other______________________

Allergies: Please list any foods, drugs, or other allergens, or check "none known": **None known** __

____

____

Current Medications: Do you take or use any of the following?

Laxatives **Y N** Pain relievers **Y N** Antacids **Y N**
Cortisone **Y N** Hormones **Y N** Sleeping pills **Y N**
Tranquilizers **Y N** Thyroid medication **Y N** Antidepressants **Y N**

Please list prescription medications, over the counter medications, vitamins or other supplements you are taking:____

____

For the following sections, please circle one of the following:

Y = a condition you have now. **P** = a condition you have had in the past. **N** = you've never had. Please mark an asterisk (*) by any areas you would like to clarify with the doctor.

Patient name: ____ DOB: ____________________

General

Weight	_____
Weight 1 yr ago	_____
Maximum weight	_____
What year?	_____
Height	_____
Fatigue	Y P N

Skin

Rashes	Y P N
Eczema, hives	Y P N
Acne, boils	Y P N
Itching	Y P N
Color change	Y P N
Lumps	Y P N
Nights sweats	Y P N

Head

Headaches	Y P N
Head Injury	Y P N

Eyes

Impaired vision	Y P N
Glasses or contacts	Y P N
Eye pain	Y P N
Tearing or dryness	Y P N
Double vision	Y P N
Glaucoma	Y P N
Cataracts	Y P N

Ears

Impaired hearing	Y P N
Ringing	Y P N
Earache	Y P N
Dizziness	Y P N

Nose and Sinuses

Frequent colds	Y P N
Nose bleeds	Y P N
Stuffiness	Y P N
Hay fever	Y P N
Sinus problems	Y P N

Mouth and Throat

Frequent sore throat	Y P N
Sore tongue	Y P N
Gum problems	Y P N
Hoarseness	Y P N
Dental cavities	Y P N

Neck

Lumps	Y P N
Swollen glands	Y P N
Goiter	Y P N
Pain or stiffness	Y P N

Respiratory

Cough	Y P N
Sputum	Y P N
Spitting up blood	Y P N
Bronchitis	Y P N
Pleurisy	Y P N
Emphysema	Y P N
Wheezing	Y P N
Asthma	Y P N
Shortness of breath	Y P N
" at night	Y P N
" on lying down	Y P N
" on exertion	Y P N
Difficulty breathing	Y P N
Pain on breathing	Y P N
Pneumocystis	Y P N
Tuberculosis	Y P N

Cardiovascular

Heart disease	Y P N
Chest pain	Y P N
Angina	Y P N
Palpitations, fluttering	Y P N
High blood pressure	Y P N
Heart murmur	Y P N
Rheumatic fever	Y P N
Swelling in ankles	Y P N

Gastrointestinal

Nausea	Y P N
Vomiting	Y P N
Vomiting blood	Y P N
Bowel movements - how often?	______
Is this a change?	Y N
Blood in stool	Y P N
Gallbladder disease	Y P N
Liver disease	Y P N
Jaundice (yellow skin)	Y P N
Change in thirst	Y P N
Change in appetite	Y P N
Trouble swallowing	Y P N
Belching/passing gas	Y P N
Heartburn	Y P N
Ulcer	Y P N
Hemorrhoids	Y P N

Urinary

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

Female Reproductive

First day of last menstrual cycle _______
Average number of days _______
Length of cycle _______
Bleeding between periods Y P N
Are cycles regular? Y P N
Pain during intercourse Y P N
Painful menses Y P N
Excessive flow Y P N
Do you use birth control? Y P N
What type? ________________________
How long? _______
Number of pregnancies _______
Number of live births _______
Number of miscarriages _______
Number of abortions _______
Difficulty conceiving Y P N
Menopausal symptoms Y P N
Are you sexually active? Y P N
Sexual difficulties Y P N
Sexually transmitted infection Y P N
Sexual Orientation: Heterosexual ____
Bisexual ____
Homosexual ____

Breasts

Do you do a monthly self exam? Y P N
Lumps Y P N
Pain or tenderness Y P N
Nipple discharge Y P N

Male Reproductive

Hernias Y P N
Testicular masses Y P N
Testicular pain Y P N
Are you sexually active? Y P N
Sexual difficulties Y P N
Prostate Disease Y P N
Sexually Transmitted Infection Y P N
Discharge or sores Y P N
Sexual Orientation: Heterosexual____
Bisexual____
Homosexual____

Musculoskeletal

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

Blood

Anemia Y P N
Bleed or bruise easily Y P N

Peripheral Vascular

Thrombophlebitis Y P N
Cold hands/feet Y P N
Varicose veins Y P N

Neurologic

Fainting Y P N
Seizures Y P N
Paralysis Y P N
Muscle Weakness Y P N
Numbness or tingling Y P N
Loss of memory Y P N

Emotional

Depression Y P N
Mood Swings Y P N
Anxiety or nervousness Y P N
Tension Y P N

Endocrine

Hypothyroid Y P N
Heat or cold intolerance Y P N
Excessive thirst Y P N
Excessive hunger Y P N
Diabetes Y P N

Habits

What are your main interests and hobbies?
____
____
____
Do you exercise? Y P N
What forms?__________________________
____
How often?___________________________
____
How many meals do you eat daily?_____
Sleep well? Y P N
Awaken rested? Y P N
Average 6-8 hours sleep? Y P N
Take vacations? Y P N
Enjoy your work? Y P N
Spend time outside? Y P N
How many hours/day do you:
Watch television? ______
Read? ______
Do you use tobacco? Y P N
Use alcoholic beverages Y P N
Use recreational drug Y P N
Treated for alcoholism Y P N
Treated for drug abuse Y P N

Are there any other issues not mentioned that you would like to discuss?______________________
____

Patient name: ____ DOB: ____________________