Original Date:
Dates Revised:

Health History Questionnaire

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

Name: *(Last, First, M.I.):*	**Sex:** ☐ M ☐ F	**DOB:**
Address:		
City:	**State:**	**Zip:**
Home Telephone:	**Work Telephone:**	
Cell Telephone:	**Email Address:**	
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Emergency Contact 1:	**Telephone Number:**	
Emergency Contact 2:	**Telephone Number:**	
Reason You Are Here: What issues would you like to discuss today?		
Expectations: What are your expectations regarding your initial visit? What are you hoping to get out of this visit?		
Readiness For Change:		

HEALTH TEAM

Personal Doctor:	**Date of Last Physical Exam:**
Cardiologist:	**Neurologist:**

List other members of your health team including medical specialists, nutritionists, chiropractors, acupuncture, massage therapists

PERSONAL HEALTH HISTORY

Height:	**Current Weight:**	**Current Waist:**	
Greatest Adult Weight:		**Greatest Adult Waist:**	
Lowest Adult Weight:		**Smallest Adult Waist:**	
Weight at 16 Years of Age:		**Waist at 16 Years of Age:**	
Immunizations and dates:	☐ Tetanus:	☐ Hepatitis:	☐ Influenza:

Please turn to next page

Prior Medical Conditions
Please indicate if you have or have had any of the medical conditions listed below and provide the year diagnosed severity, and outcome.

Medical Condition	Year Diagnosed	Severity	Outcome
Heart Disease			
Blood Clots/Phlebitis			
Jaundice or Hepatitis			
Asthma/Emphysema			
Ulcers			
Thyroid Disease			
Gallstones			
Diabetes			
Anemia			
Arthritis			
Neurological Problems			
Blood Pressure			
Cancer:			
(type)			
(type)			
Other:			

Please list all chronic medical conditions, major previous illnesses, or accidents not mentioned above and indicate date, severity, and outcome.

Medical Condition	Year Diagnosed	Severity	Outcome

Surgeries/Hospitalizations

Year	Reason

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers, herbals, and supplements

Drugs	Over The Counter (OTC) Medications	Herbals and Supplements

Allergies to Medications

Name the Drug	Reaction You Had

Please turn to next page

FAMILY HEALTH HISTORY

	[A]live / [D]eceased	Significant Health Problems		[A]live / [D]eceased	Significant Health Problems
Father	A / D		**Children**	☐ M ☐ F	
Mother	A / D			☐ M ☐ F	
Siblings	☐ M ☐ F A / D			☐ M ☐ F	
	☐ M ☐ F A / D			☐ M ☐ F	
	☐ M ☐ F A / D		**Grandmother** *Maternal*	A / D	
	☐ M ☐ F A / D		**Grandfather** *Maternal*	A / D	
	☐ M ☐ F A / D		**Grandmother** *Paternal*	A / D	
	☐ M ☐ F A / D		**Grandfather** *Paternal*	A / D	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)						
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)						
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)						
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)						
Diet	Are you dieting?				☐ Yes	☐ No	
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No	
	# of meals you eat in an average day?						
	Rank fat intake	☐ Hi	☐ Med	☐ Low			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola			
	# of (12oz) cups/cans per day?						
Artificial Sweeteners	☐ Yes ☐ No						
	# of packets in an average day?						
Alcohol	Do you drink alcohol? ☐ Yes ☐ No ☐ Quit						
	If yes, what kind?						
	How many drinks per week?						
Tobacco	Do you use tobacco? ☐ Yes ☐ No ☐ Quit	Age First used	# of years	Quantity			
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day			
Drugs	Do you currently or have you in the past used recreational or street drugs?				☐ Yes	☐ No	
	Type	☐ Quit	Year				
	Type	☐ Quit	Year				
	Type	☐ Quit	Year				

Please turn to next page

Exercise	Years Ago	Primary Type	Frequency/Week	Minutes/Session
	Last Year			
	11-20			
	21-30			
	31-40			
	41-50			
	>51			
	Current hobbies & recreation:			

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No

WOMEN ONLY

What changes do you feel during your period?		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Date of last prostate and rectal exam?

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	