CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

List your current health concerns, in order of priority with the most important first, including those for which you are seeking care. Then list any other ongoing health problems. Record date of onset and √ appropriate boxes for each.

Problem/Concern Listed in order of priority	**Date of Onset**	**Current Severity** (Check Box)			**Treatment Success So Far** (Check box)		
Start with most important first		Mild	Mod	Severe	Good	Fair	Poor

When was the last time you felt well? _____ Did something trigger your change in health? _____

When did you last receive health care? _____ For what concern? _____

Prescription and over-the-counter medications you are currently taking (include dosages):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Dietary supplements, nutrients and herbs you are currently taking (include dosages):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies – Drugs:

_____

_____

Allergies – Foods and Other:

_____

_____

Name: _____ Date of Birth: _____ Date: _____

Medical Conditions: On the short line in front of each condition, mark those you have ever had with a ***P*** (for past condition) or an ***O*** (for ongoing condition). Write the original date of onset in the empty space after the condition.

___ ADD/ADHD
___ AIDS / HIV
___ Allergies
___ Anemia, type_____
___ Alcohol/drug problem
___ Anorexia / bulimia
___ Anxiety disorder
___ Arthritis, type_____
___ Asthma
___ Atrial fibrillation
___ Bipolar disorder
___ Bleeding disorder
___ Back pain
___ Cancer, type:
_____
___ Cataracts
___ Cholesterol problem
___ Chronic fatigue syndrome
___ Coronary artery disease
___ Depression, type:
_____
___ Diabetes, type_____
___ Emphysema
___ Epilepsy / seizure
___ Esophageal reflux/GERD
___ Fibromyalgia
___ Glaucoma
___ Goiter
___ Gout
___ Heart attack
___ Heart disease
___ Heart murmur
___ Hepatitis, type
___ High blood pressure
___ Irritable bowel syndrome
___ Jaundice
___ Kidney disorder
___ Kidney stones
___ Liver disease
___ Lung disease
___ Lupus
___ Mental illness
___ Migraines
___ Obsessive compulsive dis
___ Osteoporosis
___ Pancreatitis
___ Panic disorder
___ Periodontal disease
___ Pneumonia
___ Polio
___ Psoriasis
___ Psychiatric hospitalization
___ Rheumatic fever
___ Rheumatoid arthritis
___ Sinusitis, last date_____
___ Sjogrens syndrome
___ Sleep apnea
___ Stroke / TIA
___ Thyroid problem, type_____
___ TMJ
___ Tuberculosis
___ Ulcerative colitis / Crohn's dis
___ Ulcer, type_____
___ Urinary infection, last date___

Female conditions:

___ Endometriosis / uterine fibroid
___ Ovarian cysts /polycystic ovaries
___ Pelvic inflammatory disease
___ Sexually transmitted disease
___ Vaginitis, last date_____

Male conditions:

___ Enlarged prostate
___ Prostatitis
___ Sexually transmitted disease

Other health problems:

_____
_____
_____

List Hospitalizations, surgeries, x-rays or special studies you have had:

Year	Hospitalization or Procedure	Reason	Outcome

Name: _____ Date of Birth: _____ Date: _____

Social history: Describe yourself including your age, gender, job, school, who you live with, and how you spend your time. With whom do you have a supportive relationship? What in your life is most meaningful to you?

Health Habits

Substance or activity	How much?
Caffeine (coffee, tea, soft drinks)	No / Yes cups/day of coffee, cups/day tea, cups (8-oz)/day soft drinks
Cigarettes	No / Yes How much? Total years you've smoked? If past smoker: Quit date: packs/day x yrs
Are you interested in quitting?	NA (not applicable) / No / Yes
Chew Tobacco	No / Yes Amount If past user: Quit date: Used for yrs
Alcohol	No / Yes What kinds/how much/how often? If past use: Quit date: Why did you quit?
Drugs	No / Yes What do you use now? In the past?
Exercise	Type & frequency
Nutrition/Diet	Type

Which of your blood relatives have had the following conditions? At what age did condition develop, if known?

Alcohol/Drugs _____ Cancer _____ High blood pressure _____

Allergies/asthma_____ Cholesterol dis_____ Kidney disease _____

Alzheimer's dis_____ Diabetes _____ Mental illness _____

Anemia _____ Epilepsy _____ Osteoporosis _____

Arthritis _____ Heart disease _____ Stroke _____

Family History	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
Medical disorders with age of onset							
If deceased, age and cause							

Name: _____ Date of Birth: _____ Date: _____

Review of Symptoms

Mark each symptom you have had **IN THE PAST THREE MONTHS** with an ***R*** for resolved (completely gone) or ***C*** for continuing (you still have the symptom). Provide any additional requested information.

SKIN
___Rashes
___Eczema
___Acne
___Itching
___Fungal infections
___Hair loss
___Facial hair in female
___Dry skin / scalp
___Color change
___Lumps
___Slow healing sores / ulcers
___Flushing

NOSE AND SINUSES
___Stuffiness
___Hay fever
___Sinus problems
___Frequent colds
___Nose bleeds
___Loss of smell

EYES AND EARS
___Itchy eyes
___Watery eyes
___Dry eyes
___Swollen / painful eyes
___Red eyes
___Impaired vision / blurriness
___Floaters in vision
___Color blindness
___Double vision
___Hearing difficulty
___Ringing in ears
___Earaches / ear infection

MOUTH AND THROAT
___Sore throat
___Teeth grinding
___Sore tongue / lips
___Gum problems
___Hoarseness
___Gagging / choking
___Difficulty swallowing

IMMUNE
___Frequent infections
___Persistent swollen glands
___Slow wound healing

HEAD / NECK
___Headaches
___Migraines
___Faintness
___Dizziness
___Jaw pain
___Swollen glands
___Pain or stiffness

RESPIRATORY
___Chest congestion
___Wheezing / asthma
___Bronchitis
___ Pneumonia
___Emphysema
___Difficulty / pain breathing
___Shortness of breath
___Snoring excessively
___Cough ___Wet or ___Dry
___Coughing blood

CARDIOVASCULAR
___Angina / chest pain
___High / low blood pressure
___Murmurs
___Blood clots
___Irregular or rapid heart beat
___Palpitations / fluttering
___Swelling in ankles

CIRCULATION
___Easy bleeding or bruising
___Anemia
___Deep leg pain
___Varicose veins
___Cold hands / feet
___Fainting or collapse

MENTAL/EMOTIONAL
___Easily stressed
___Mood swings
___Anxiety or nervousness
___Considered / attempted suicide
___Depression
___Poor concentration
___Poor memory
___Panic
___Other

ENDOCRINE
___Heat or cold intolerance
___Excessive hunger
___Excessive thirst
___Low blood sugar
___Fatigue
___Other_____

DIGESTION
___Trouble swallowing
___Heartburn / acid reflux
___Loss of appetite
___Nausea / vomiting
___Belching / passing gas
___Bloating of abdomen
___Diarrhea
___Constipation
___Pain or cramps in abdomen
___Mucous in stools
___Bloody stool / black tarry stool
___Hemorrhoids
___Itchy / burning anus
___Rectal pain
___Liver / gall bladder trouble
___Jaundice (yellow skin)
___Change in bowel habits
Bowel Movements: How often?_____
Stools ___Hard ___Firm
___Soft ___ Loose
___Colonoscopy abnormal Date_____
Date of last colonoscopy _____
Normal / Abnormal

MUSCLES / JOINTS/ BONES
___Joint pain
___Muscle pain
___Muscle spasms / cramps
___Low back pain
___Sciatica

NEUROLOGIC
___Seizures
___Paralysis
___Muscle weakness
___Numbness or tingling
___Change in headaches
___Vertigo or dizziness
___Loss of balance

Name: _____ Date of Birth: _____ Date: _____

Review of Symptoms

Mark each symptom you have had **IN THE PAST THREE MONTHS** with an ***R*** for resolved (completely gone) or ***C*** for continuing (you still have the symptom). Provide any additional requested information.

GENERAL
___Poor sleep / insomnia
___Fatigue / low Energy
___Generally feel hot
___Generally feel cold
___Chills
___Fevers
___Unusual sweats
___Poor appetite
___Constant hunger
___Cravings, please specify_____
___Peculiar taste in mouth, describe_____
___Experience high stress
___Weight loss - unexpected
Date of last tetanus vaccine _____

URINARY
___Pain on urination
___Frequent urination
___Urgent urination
___Blood in urine
___Urinary infections, frequency ____
___Urination at night ___ x/night
___Urine leakage
___Kidney stones

MALE ONLY
___Hernias
___Testicular masses
___ Testicular pain
___Discharge or sores
___Difficulty in initiating urine stream
___Weak / diminished urinary stream
___Bladder not emptying completely
Are you sexually active? Yes No
Sexual partner: male / female / both
Contraceptive method: _____
___Sexual dysfunction
___Can't maintain erection
___Erections less firm
___Premature ejaculation
___Lower sex interest / libido
Any other male difficulties?_____
Date of last prostate exam _____
Normal / Abnormal
Prostate exam abnormal in past? No Yes Date ___

FEMALE ONLY
___Pregnant or possibly pregnant
___PMS: days per month/severity_____
___Menstrual cramps: # of days/severity_____
___Painful sex
___Low libido / loss of interest in sex
___Trouble conceiving / infertility
___Heavy or excessive flow or clots
___Irregular periods, describe_____
___Bleeding between periods
___Lack of periods
___Hot flashes or menopausal symptoms
___Spotting after menopause
___Vaginal dryness or pain
___Unusual vaginal discharge Color_____
___Vaginal irritation / odor
___Breast pain/tenderness
___Fibrocystic breasts
___Nipple discharge
___Breast Lumps
Any other feminine difficulties?_____
Age at which menses began_____
Age of last menses (if post-menopausal) _____
Day 1 of period to Day 1 of next period _____days
Length of menstrual flow_____
Amount of flow, describe_____
Last menstrual period, beginning date_____
Last period before that, beginning date_____
Are you sexually active? No Yes
Sexual partner: male / female / both
Want to discuss contraception options? No Yes
Contraceptive method _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Pap smear abnormal in past? No Yes Date _____
Date of last Pap smear _____
Normal / Abnormal
Mammogram abnormal in past? No Yes Date_____
Date of last mammogram _____
Normal / Abnormal

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Medical Symptoms Questionnaire (MSQ)

Patient Name_____ Date_____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale

0 – ***Never or almost never*** have the symptom
1 – ***Occasionally*** have it, effect is ***not severe***
2 – ***Occasionally*** have it, effect is ***severe***
3 – ***Frequently*** have it, effect is ***not severe***
4 – ***Frequently*** have it, effect is ***severe***

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(Does not include near or far-sightedness)

Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

Total _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Total _____

Grand Total _____