

PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

CONTEXT OF CARE

Successful healthcare is only possible when the physician has a complete understanding of the patient on physical, mental, and emotional levels. The nature of your responses to the following questions will go a long way in assisting our understanding of your true condition. Your time, thoughtfulness and honesty in completing this overview will greatly assist us in meeting your healthcare needs.

- What do you know about the naturopathic approach to health?
- What are some of the expectations you have from **this** visit?
- What are some **long term** expectations you have of your personal physician? (how do you believe we may best assist you in attaining better health?)
- What is your present level of commitment to learn and implement the healthy lifestyle changes that will improve your overall health and well-being? (Scale 0-10, with 10 being 100% committed)
0% 0 1 2 3 4 5 6 7 8 9 10 100%
- What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)
- What behaviors or lifestyle habits do you currently engage in regularly that might be negatively impacting your health? (please list)

- What obstacles do you foresee that may keep you from adhering to therapeutic protocols or prevent you from addressing any lifestyle factors that may be undermining your health?

HEALTH HISTORY

- Please list any current or recent health care providers:

| Name | Dates | Care Provided |
|-------|-------|---------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

- What are your most important health concerns? Please list in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

- Please list any hospitalizations, surgeries, or imaging (X-rays, CAT scans, EEGs, EKGs, etc.) that you have had?

| | | | |
|-------|------------|-------|------------|
| _____ | Year _____ | _____ | Year _____ |
| _____ | Year _____ | _____ | Year _____ |
| _____ | Year _____ | _____ | Year _____ |

- Have you suffered any major traumas (e.g. car accidents, falls, blows to the head, etc.)?

ALLERGIES

- Please list any allergies (environmental, food, medications, pets etc.)

TOXICITY EXPOSURE

* What is your occupation? _____

* Do you currently work in the presence of toxic fumes or chemicals? Y N Don't know

- * Do any of your hobbies involve toxic materials? Y N
- * Are you exposed to second hand smoke? Y N
- * What do you use for drinking water? Tap water Filtered/Purified Well Bottled

MEDICATIONS/SUPPLEMENTS

- Do you take or use any of the following:

| | | | | | |
|---------------|-----|--------------------|-----|----------------|-----|
| Laxatives | Y N | Pain relievers | Y N | Antacids | Y N |
| Tranquilizers | Y N | Thyroid medication | Y N | Sleeping pills | Y N |
- Are there any other over the counter medications that you take regularly?

- Please list any prescription medications with dosages and length of time taken:

| | |
|--|--|
| | |
| | |
| | |
| | |
| | |
| | |

- Please list all nutritional supplements, herbs, or homeopathics that you take regularly:
-
-
-

HABITS

Caffeine use (how much): _____ Alcohol use (how much): _____

Do you drink cola/other sodas? Y N If yes what and how many per day? _____

Do you use tobacco? Y N Smoked previously? Y N

If yes, how many years? _____ How many packs per day? _____

Mood-altering substance use (i.e. marijuana, cocaine – past and present): _____

Do you exercise? If yes, what type and how often?

Main interests and hobbies?

How do you relax?

Do you have a religious or spiritual practice? Y N

Spend time outside? Y N

Do you enjoy your work? Y N Have a supportive relationship? Y N somewhat

Take vacations? Y N Have a history of abuse? Y N

Do you watch television Y N How many hours per day? _____
Do you read? Y N How many hours per day? _____

SLEEP

Average hours of sleep per night? _____ Do you wake refreshed? Y N
Do you have trouble falling asleep? Y N If yes, what keeps you up? _____
Do you sleep through the night? Y N If not, what time do you usually wake? _____
Do you have recurrent dreams? Y N If yes, what is the theme _____

GENERAL

Height _____ Weight _____ Weight one year ago? _____
Maximum weight ever _____ date _____

What would you estimate your energy level to be on a scale of 1-10?
Poor energy 1 2 3 4 5 6 7 8 9 10 Great energy

When during the day is your energy the best? _____ worst? _____

Please list the five most significant, stressful events in your life, beginning with the most recent.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

On a scale of 1-10 (10 being extreme stress), describe the level of stress you **currently** experience:

1 2 3 4 5 6 7 8 9 10

In what areas of life are you experiencing stress?

Family Money/Finances Relationship/Marriage Work Health Children
Other: _____

PAST MEDICAL HISTORY

Have you ever had food poisoning? Y N How many times? _____ Approximate dates? _____
Was the offending bacteria identified? Y N If so what? _____

What childhood illnesses have you had and what was your approximate age? (please circle)

| | | | | | |
|--------------------------------|-------|-----------|------------------|-------|-----------|
| Rubella (German 3 day measles) | Y N | Age _____ | Measles (2 week) | Y N | Age _____ |
| Mumps | Y N | Age _____ | Chickenpox | Y N | Age _____ |
| Roseola | Y N | Age _____ | Whooping cough | Y N | Age _____ |
| Polio | Y N | Age _____ | Rheumatic Fever | Y N | Age _____ |
| Scarlet Fever | Y N | Age _____ | Asthma | Y N | Age _____ |
| Eczema | Y N | Age _____ | Diphtheria | Y N | Age _____ |
| Mononucleosis | Y N | Age _____ | Other | _____ | _____ |

IMMUNIZATIONS

| | | | |
|------------------------------|-----|-------------|-----|
| Polio | Y N | Pertussis | Y N |
| Tetanus shot (not antitoxin) | Y N | Diphtheria | Y N |
| Measles/Mumps/Rubella | Y N | Other _____ | |

Did you experience any reactions to or side effects from any immunizations that you know of? (if yes, please describe)

REVIEW OF SYSTEMS

Please check any health condition or symptom you have or have had:

(Circle **C** for **C**urrent condition and/or **P** for **P**ast condition. Leave blank if you have never had the condition.)

Respiratory

| | | |
|---|---|--|
| C | P | Asthma |
| C | P | Chronic bronchitis |
| C | P | Emphysema |
| C | P | Pain with breathing |
| C | P | Wheezing |
| C | P | Trouble breathing/ Shortness of breath |
| C | P | Shortness of breath lying down |
| C | P | Cough |
| C | P | Coughing up sputum/blood |
| C | P | Pneumonia |
| C | P | Tuberculosis |

Cardiovascular

| | | |
|---|---|----------------------------------|
| C | P | Heart disease |
| C | P | Heart attack |
| C | P | Angina |
| C | P | Heart murmur |
| C | P | High/Low blood pressure |
| C | P | High cholesterol/low cholesterol |
| C | P | Heart palpitations |
| C | P | Chest pain |
| C | P | Blood clots |
| C | P | Rheumatic Fever |
| C | P | Swelling in ankles |

Endocrine

| | | |
|---|---|--------------------------------|
| C | P | Hypothyroid |
| C | P | Hyperthyroid |
| C | P | Low blood sugar (hypoglycemia) |
| C | P | Fatigue |
| C | P | Diabetes (Childhood onset) |
| C | P | Diabetes (Adult onset) |
| C | P | Intolerance to heat or cold |
| C | P | Excessive hunger or thirst |
| C | P | Seasonal depression |

Neurological

| | | |
|---|---|-------------------------------------|
| C | P | Seizures |
| C | P | Muscle weakness |
| C | P | Memory loss |
| C | P | Tremors |
| C | P | Dizziness or vertigo |
| C | P | Numbness or tingling in extremities |
| C | P | Paralysis |

Skin

| | | |
|---|---|-----------------|
| C | P | Rashes |
| C | P | Acne/Boils |
| C | P | Color change(s) |
| C | P | Lumps |
| C | P | Eczema, hives |
| C | P | Itching |
| C | P | Hair loss |
| C | P | Night sweats |

Head

| | | |
|---|---|------------------|
| C | P | Headache |
| C | P | Migraines |
| C | P | Head injury |
| C | P | Jaw/TMJ problems |

Ears

| | | |
|---|---|----------------------------|
| C | P | Ringings in ears/tinnitus |
| C | P | Earaches |
| C | P | Ear infection/fluid in ear |
| C | P | Hearing loss |

Nose & Sinuses

| | | |
|---|---|--------------|
| C | P | Stuffiness |
| C | P | Hayfever |
| C | P | Nasal polyps |

Eyes

| | | |
|---|---|------------------------|
| C | P | Spots in eyes/floaters |
| C | P | Cataracts |

- C P Post nasal drip
- C P Sinus infections
- C P Nose bleeds
- C P Loss of smell

- C P Eye strain/pain
- C P Blurred vision
- C P Eye surgery
- C P Tearing or dry eyes
- C P Glasses/contacts

Immune System

- C P Chronic fatigue syndrome
- C P Swollen glands
- C P Frequent colds/flu
- C P Chronic infections
- C P Wounds heal slowly

- C P Glaucoma
- C P Double vision
- C P Color blindness
- C P Macular degeneration or detached retina

Mouth & Throat

- C P Trouble or pain with swallowing
- C P Teeth grinding
- C P Gum problems
- C P Excessive saliva
- C P Hoarseness/loss of voice
- C P Mouth/tongue sores
- C P Dry mouth/decreased saliva
- C P Tooth loss
- C P Clicking jaw
- C P Cavities, root canal - How many_____?

Blood/Peripheral Vascular

- C P Blood clots
- C P Phlebitis
- C P Easy bleeding/bruising
- C P Deep leg pain
- C P Varicose veins
- C P Swollen ankles
- C P Rheumatic fever
- C P Anemia
- C P Cold hands/feet
- C P Anti-clotting medication

Gastrointestinal

- C P Appetite changes increase/decrease
- C P Gas/Bloating
- C P Ulcer
- C P Abdominal pain/cramps
- C P Colon polyps
- C P Gallbladder problems/gallstones
- C P Liver problems
- C P Heartburn/Reflux
- C P Constipation
- C P Diarrhea
- C P Nausea or vomiting
- C P Belching
- C P Vomiting blood
- C P Blood in stool
- C P Change in bowel movements
- C P Black stools
- C P Hemorrhoids/rectal fissures

Musculoskeletal

- C P Joint pain or stiffness
- C P Leg pain
- C P Muscle cramps or spasms
- C P Back pain
- C P Neck pain
- C P Back surgery
- C P Arthritis
- C P Muscle weakness
- C P Sciatica
- C P Car accident - how many_____?
- C P Spinal disc problems
- C P Osteoporosis
- C P Broken Bones

Do you have difficulty with bowel movements?

Y N

How often do you have a bowel movement?

Are your stools: liquid soft formed hard

Mental/Emotional

- C P Mood Swings
- C P Considered/attempted suicide
- C P Trouble concentrating
- C P Depression
- C P Anxiety/Nervousness
- C P Treated for emotional problems

Men's Health

- C P Pain/burning with urination
- C P Increased urinary frequency
- C P Increased urinary urgency
- C P Kidney stones
- C P Frequency at night
- C P Frequent infections

- C P Hernias
- C P Testicular masses
- C P Testicular or groin pain
- C P Prostate problems
- C P Discharge or sores
- C P Impotence/erectile dysfunction
- C P Premature ejaculation
- C P Chlamydia
- C P Gonorrhea
- C P Condyloma

C P Inability to hold urine

C P Herpes

C P Syphilis

| |
|--|
| Are you sexually active? |
| What form of birth control do you use? |
| Do you do self-testicular exam? |

Women's Health

C P Irregular cycles

C P Heavy bleeding

C P Bleeding between cycles

C P Clotting

C P Cramping with menses

C P Menopausal symptoms

C P Breast lumps

C P Abnormal PAP

Are you sexually active?

What form of birth control do you use?

Chlamydia Y N P

Gonorrhea Y N P

Condyloma Y N P

Herpes Y N P

Syphilis Y N P

Age of first Menses:

Age of last menses (if menopausal):

Length of cycle:

Length of Menses:

Painful menses: Y N Past

PMS symptoms: _____

C P Endometriosis

C P Ovarian cysts

C P Uterine fibroids

C P Painful intercourse

C P Sexually transmitted infection

C P Difficulty conceiving

C P Hysterectomy

C P Cervical dysplasia

Do you do self- breast exams? Y N

Breast pain/tenderness? Y N

Any nipple discharge? Y N

Do you get regular mammograms?

Date of last annual exam/PAP _____

Number of Pregnancies:

Number of Births:

Number of miscarriages:

Number of abortions:

FAMILY HEALTH HISTORY

Please fill in all known conditions/illnesses found in your family. Some examples include: Cancers (be specific), Alzheimer's disease, Auto-Immune Disorders (SLE, Rheumatoid arthritis, Multiple Sclerosis, etc), Kidney disease, Heart disease, High cholesterol, Hypertension, Thyroid problems, Allergies, Asthma, Skin conditions (eczema, psoriasis, etc.), Depression, Anxiety, Gastro-intestinal issues (polyps, ulcers, IBS, etc.), Anemia, Diabetes, Epilepsy/Seizures, Mental Illness, Alcoholism, Glaucoma/Cataracts, etc.

Please list the **Age**, or age of death if deceased, for each family member and include

All Known **Conditions/Illnesses** :

Mother _____

Father _____

Brothers _____

Sisters _____

Grandfathers _____

Grandmothers _____

Aunts/Uncles/Cousins _____

Any other relevant family history? _____

What is your heritage? German _____ Nordic _____ Celtic _____
African _____ Native American _____ Hispanic _____ European _____
Asian _____ Other _____

Is there anything you would like to add or comment on?

Thank you for your time and effort in completing this form. We look forward to providing you with the best possible care.