Health History Questionnaire

Name: Sex: M F Date:

Date of Birth: Place of Birth:

Age: Occupation:

Address:

E-mail: Phone: (H) (C)

Marital Status: Number of Children:

Major complaint/s:

How long has it been a problem? If it’s pain, please describe it, whether the pain is sharp or dull, fixed or traveling/radiating to different areas, whether it’s predominant in the morning/day/night?

Have you been diagnosed for the problem by a family physician?

Mitigating Factors: Are you aware of factors that make it worse/better?

Alleviated by heat or cold?

Aggravated by cold/damp/hot weather?

Better with rest or movement?

Worse or better with pressure?

What treatments/meds/herbs have you already tried? Have they helped?

Medical History: Please list any related or other significant medical history/trauma/surgery. Please include the date/year of its occurrence.

Allergies:

Respiratory disorders:

Diabetes:

High Blood Pressure:

Cancer:

Heart Disease:

Thyroid Disease:

Other auto-immune disorders:

Hepatitis:

Surgeries:

Accidents or Trauma:

Any mental illness:

Other significant illness:

Are you on medications:

Supplements/herbs:

Family Medical History: any major family illnesses-cancer, heart attack, stroke, diabetes?

Chills and Fever: Do you ever have any of the following? □ chills □ fever □ both chills and fever

If so, please describe (how often, how long, time of day or circumstances, etc)

Body temperature: Do you usually run warm/cold/normal? Do you have any particular area in the body that feels cold or hot, such as chest or extremities?

Perspiration: Do you perspire? Y N

Do you perspire with exercise? Y N

Any odor or color to the perspiration?

Do you perspire at night?

Do you perspire spontaneously?

Thirst, Appetite, Taste:

Do you feel unusually thirsty?

How much water do you consume per day?

Any preference for hot or cold/iced drinks?

Do you tend to sip or gulp your drinks?

How is your appetite?

Any weight gain or loss? If so, please describe amount and over what period of time

Any unusual tastes in your mouth? (e.g., bitter, sweet, salty, etc):

Diet: Please describe your daily diet and time meals on average:

Breakfast:

Lunch:

Dinner:

Snacks:

Do you take these meals at the same time every day or do they vary?

Is there any food that you cannot digest/food allergies?

What temperature of food do you prefer: raw/cold/cooked?

What is the largest meal of the day?

Do you skip a meal?

How does the food usually affect you: do you feel energized/drowsy/tired after food?

Any bloating/abdominal distention/gas/borborygmus (intestinal gurgling sounds)?

Any belching, acid reflux, nausea/vomiting?

Any particular food cravings?

Drinks: Coffee/how much?

Caffeinated drinks:

Coke:

Black tea:

Green tea:

Alcohol: if yes how much?

Tobacco/Recreational Drugs:

Elimination: Urination and Stool

How many times a day do you urinate on average?

Do you urinate at night/how many times?

What is the color? Is it cloudy or clear?

Amount: scanty/profuse?

Any burning on urination?

Any unusual odor?

Do you have difficulty starting?

Urgency/Dribbling?

Kidney Stones?

Sores on genitals?

Stool:

How often do you have a bowel movement per day?

What is the consistency of your stool: formed/loose/hard/soft?

Are you prone for constipation/diarrhea?

Had you had a tendency for constipation/diarrhea in your childhood or teenage years?

Any undigested food/mucus/blood in the stool?

Any difficulty passing stool?

Do you strain?

Hemorrhoids?

Any abdominal pain before or after passing the stool?

Does/did your stool change with your period?

Sleep: How many hours do you sleep at night?

What time do you go to bed and rise in the morning?

Do you feel rested when you wake up?

Do you have difficulty falling asleep?

Do you have difficulty staying asleep?

When you wake up at night how long is that before you fall back asleep?

Are you a light sleeper?

Do you dream/disturbing dreams?

Energy: On the scale of 1-10 (ten being the top) how would you rate you energy on average?

Are you more a morning or night person?

What is the best time of the day?

What gives/saps you/r energy? (food, exercise, sex etc.)

What do you do to relax?

Exercise: What type of exercise do you do and how often?

Stress: How would you rate your stress level today (or in the recent past)?

Emotions: How do you describe your emotions today?

Did you have any major emotional changes recently/in childhood?

Female Reproductive System/Sexual Energy:

At what age did you start your period?

When did you have your last period?

When did you start you menopause?

When you have/had your period what is/was the number of days in cycle:

How many days is/was your period?

Is/was your period the same each month? Y N

Heavy/light/medium flow?

What color is/was your flow (dark red, bright red, brown, etc)?

Any clots in your period? Y N

Any vaginal discharge? Y N

If so, please describe the color, consistency, and odor:

PMS, mood swings, irritability, cravings?

Pregnancy: how many times were you pregnant/how many deliveries?

Miscarriges?

Abortions?

Infertility?

Menopause: Hot flashes, night sweats, vaginal dryness?

Sexually transmitted disease?

How is your libido?

Male Reproductive System/Libido:

\_\_ Testicular masses

\_\_ Testicular pain

\_\_ Hernia

\_\_ Prostate problems

\_\_ Discharge or sores

\_\_ Low libido

\_\_ Erectile dysfunction

\_\_ Premature ejaculation

\_\_ Low sperm count

\_\_ Other sexual difficulty

\_\_ Sexually transmitted disease

\_\_ Sexually active

Head and Body: Do you experience headaches? Y N

If yes, how often?

Where do the headaches occur (front, back, side of head, etc)?

What is the quality of the headache (sharp, dull, throbbing, etc)?

What time of day do the headaches begin?

What do you think may trigger them?

Is there anything that makes the headaches better or worse (i.e., pressure, hot or cold applications, etc?

Do you ever experience dizziness? Y N

Do you have pain in any other part of the body: neck, shoulders, elbows, wrists, hands, back, hips, knees, ankles?

Chest and Abdomen:

Any shortness of breath/palpitations?

Any respiratory problems in the past or present?

Chest pain? Y N

Blood pressure:

Any discomfort/bloating/distention in the abdomen?

EYES

\_\_ Impaired vision

\_\_ Glasses/contacts

\_\_ Far-sighted

\_\_ Near-sighted

\_\_ Double vision

\_\_ Colour blindness

\_\_ Night blindness

\_\_ Sensitivity to sun

\_\_ Pain

\_\_ Redness

\_\_ Itching

\_\_ Dryness

\_\_ Discharge

\_\_ Blurring

\_\_ Excessive tearing

\_\_ Spots/Floaters

\_\_ Blind spot

\_\_ Glaucoma

\_\_ Cataracts

\_\_ Other

EARS

\_\_ Ringing

\_\_ Discharge

\_\_ Pain/Aches

\_\_ Deafness

\_\_ Infections

\_\_ Wax build-up

\_\_ Other

NOSE & SINUSES

\_\_ Allergies

\_\_ Loss of smell

\_\_ Post nasal drip

\_\_ Nosebleeds

\_\_ Dryness

\_\_ Sinus infections

\_\_ Sinus pain

\_\_ Nasal congestion

\_\_ Sleep apnea

\_\_ Snoring

\_\_ Nasal Polyps

Other:

MOUTH & THROAT

\_\_ Dental cavities

\_\_ Mercury fillings

\_\_ Gum problems

\_\_ Grinding/Clenching

\_\_ Ulcers/sores

\_\_ Loss of Taste

\_\_ Pain/Soreness

\_\_ Frequent Sore throat

\_\_ Hoarseness

\_\_ Tonsillitis

\_\_ Phlegm/Mucous

\_\_ Cold sores

\_\_ Enlarged glands

\_\_ Jaw pain/clicking

\_\_ Facial pain/tics

Please highlight any of the following conditions applied

|  |  |  |
| --- | --- | --- |
|  Dry or rough skin Insomnia Constipation Fatigue Headaches Intolerance of cold Underweight or losing weight Anxiety, worry and restlessness Hyperactive: physical & mental |  Rashes Inflammatory skin conditions (including acne), easily sunburned Stomach aches/Acid reflux Diarrhea Controlling and manipulative behavior Visual problems or burning in the eyes Excessive body heat Hostility, irritability Excessive competitive drive |  Oily skin Slow digestion Sinus congestion Nasal allergies Asthma Obesity Skin growths Possessiveness, neediness, hoarding Apathy Depression Difficulty paying attention |

Please include anything else that you didn’t get covered in the questionnaire.