Health History Questionnaire

Name: ____________________________________ Date: ______________________

The following is confidential. Check off all the questions that apply to conditions you CURRENTLY have OR have experienced in the PAST THREE MONTHS. (Please make clarification notes if need be.)

Lifestyle/Habits

__Alcohol
__Drugs (non-prescrip)
__Tobacco
__Marijuana

__Cravings/Unwanted habits
__Stress Level
__Occupational Hazards

__Other therapies (massage, counseling, etc.)
__Meditation/other stress management techniques

Exercise: List _________________________
Hobbies: List _________________________

General Symptoms

__Poor appetite
__Heavy appetite
__Usually feel cold
__Usually feel hot
__Recent weight loss/gain

__Fatigue
__Lack of strength
__Heavy body sensation
__Cold hands or feet
__Hot hands or feet

__Poor circulation
__Fever
__Chills
__Night sweats
__Sweat easily

__Muscle Cramps
__Allergies
__Frequently sick
General mood: describe_______

Sleep

__Difficulty falling asleep
__Difficulty staying asleep
__Restless mind
__Restless Body
__Wake at a specific time
__Wake intermittently

__Wake dues to night sweats
__Difficulty getting back to Sleep after waking
__Difficulty getting up in morning
__Wake rested

__Heavy sleep
__Dream disturb sleep
__Recurring dreams
__Usual time of going to sleep________

Usual time of rising___________
Total hours of sleep per night______

Head, Eyes, Ears, Nose & Throat

__Glasses
__Eye strain
__Eye pain
__Red eyes
__Dry eyes
__Tearing eyes
__Itchy eyes
__Floaters in eyes
__Poor Vision
__Blurred Vision
__Night Blindness
__Glaucoma
__Cataracts

__Teeth problems
__Jaw problems(TMJ)
__Teeth grinding
__Cavities/fillings
__Dentures, partials etc.
__Gingivitis
__Sores inside mouth tongue, or gums
__Thrush
__Sores on lips
__Facial pain
__Dry mouth
__Excessive saliva

__Excessive phlegm
__Sinus problems
__Recurrent sore throat
__Lump in throat
__Swollen glands
__Enlarged thyroid
__Thyroid disorders
__Nose bleeds
__Nasal discharge
__Poor Hearing
__Deafness

__Ringing in ears
__high ring
__low buzz
__Hearing aids
__Earaches
__Headaches
__Migraines
__Concussions
__Other head/neck problems ________________________

Respiratory

__Difficulty breathing when laying down
__Difficulty inhaling
__Difficulty exhaling

__Shortness of breath
__Wheezing
__Cough
__Coughing blood

__Sputum/phlegm
__thick
__thin
colour: ________

__Asthma
__Tight chest
__Pain in chest/lungs

Cardiovascular

__High blood pressure
__Low blood pressure
__Blood clots
__Fainting
__Chest pain

__Radiating pain
__Difficulty breathing
__Heart palpations
__Tachycardia (fast heart beat – over 100beats/min)

__Bradycardia (slow heart beats less than 60beats/min)
__Irregular heart beat
__Heart disease

__Phlebitis
__Varicose veins

Musculoskeletal

__Neck pain
__Shoulder pain
__Upper back pain
__Low back pain

__Knee pain
__Joint pain
__Rib pain
__Muscle pain

__Limited range of motion
__Limited use
__Better if resting
__Better when using

What feels better?
__Hot
__Cold
__Pressure

Gastrointestinal

__Rashes
__Nausea
__Vomiting
__Acid regurgitation
__Belching
__Hiccoughing
__Bloating
__Bad breath
__Thirsty
__Prefer hot drinks
__Prefer cold drinks
__Ulcer

__Gallstones
__Diabetes
__Hypoglycemia
__Unusual taste in mouth
__Prolapsed organs
describe______________
__Laxative use
__Black stool
__Bloody stool
__Mucus in stool
__Intestinal pain or cramping; fixed or moves

__Gas
__Itchy anus
__Burning anus
__Rectal pain
__Hemorrhoids
__Anal fissures
__Constipation
__Diarrhea
Bowel movements
#___x per day/week

Texture of stool: check all that apply
__varies
__loose
__formed
__hard
__dry
__pellets
__sink
__float
__foul odor

Skin & Hair

__Rashes
__Hives
__Itching
__Ulcerations
__Eczema

__Psoriasis
__Acne
__Boils
__Dandruff
__Hair loss

__Excess hair growth
__Change in hair/skin texture
__Fungal infections
__Soft nails

__Brittle nails
__Colour of nails
describe__________________
other________________________

Neuropsychological

__Seizures/epilepsy
__Numbness
__Neuralgia
__Tics
__Poor memory
__Depression

__Anxiety
__Easily stressed
__Easily frightened
__Fearful
__Worry
__Grief

__Anger
__Irritability
__Frustration
__Difficulty making decisions
__Abuse survivor

__Considered/attempted suicide
__Seeing a counselor, psychologist, etc.
__other________________

Genito-Urinary

__Pain with urination
__Frequent urination
__UTI-bladder infection
__Urgent urination
__Blood in urine
__Bladder incontinence
__Bowel incontinence

__Incomplete urination
__Venereal disease
__Bed wetting
__wake to urinate
__Dribbling
__Increased sexual energy
__decrease sexual energy

__Kidney stones
Male health issues:
__Impotence/infertility
__premature ejaculation
__Nocturnal emissions
__Testicular problems
__Prostate problems

__Genital lesions
__Sexual active
__Birth control use
describe__________
__Date of last complete physical exam______

Gynaecology

__Age menses began
__Length of cycle
__Duration of flow
__Irregular period
__Painful period
__PMS
__Vaginal discharge
__Vaginal sores, lesions
__Vaginal odor
Date of last period________________

__Clots
Color of menstrual flow_____________
__Breast lumps/pain
__Breast enhancements or reduction
__Nipple discharge
__Birth complications

__Postpartum complications
__Infertility
__Birth control use
describe___________
Date of last gynaec. exam/PAP__________
__Hormone replacement
__# of pregnancies

__# of live births
__# of premature births
__# of miscarriages or abortions
__Pregnant
__Menopause
Age of onset_________

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