

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Address: _____

Phone: (h): _____ (w): _____ (cp): _____ Email address: _____

Emergency Contact & Number: _____

Date of Birth: ____/____/____ Age: _____ Gender: M F Marital Status: S M D W

When and where did you last receive health care? _____

For what reason? _____

Please identify the health concerns that have brought you here in order of importance below:

Condition	Past Treatment
a. _____	_____
How does this condition affect you? _____	
b. _____	_____
How does this condition affect you? _____	
c. _____	_____
How does this condition affect you? _____	
d. _____	_____
How does this condition affect you? _____	

Please list any foods, medications or environmental substances you are hypersensitive / allergic to and their reactions:

Please list any medications (prescribed or over the counter), vitamins, herbs or supplements you are currently taking:

Do you have any reason to believe you might be pregnant? Y N

If so, how far along are you? _____

Do you have any infectious diseases? Y N If yes, please identify: _____

Family History:	Father	Mother	Brothers	Sisters	Children
Check those applicable:					
How many	xxxxxx	xxxxxx	_____	_____	_____
Age (if living)	_____	_____	_____	_____	_____
Health (Good/Poor)	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Asthma/Allergies	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Age at Death	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____

Blood Pressure: What is your most recent reading: _____/_____ When was this reading? _____

Your height: _____

Your current weight: _____

Childhood Illnesses (please circle any you may have had): Scarlet Fever Rheumatic Fever

Diphtheria Mumps Measles Chickenpox German measles Polio

Other : _____

Immunizations (please circle any you may have had): Polio Tetanus Pertusis

Diphtheria Hib Hepatitis B MMR Other: _____

Hospitalizations and Surgeries :

Reason/Dates:

_____	_____
_____	_____
_____	_____

In this section please circle any symptoms/conditions you experience now and underline any you have experienced in the past:

Emotional :

Mood Swings Nervousness Mental Tension Depression Anxiety Stress

Energy and Immunity :

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose and Throat:

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts
Tearing/Dryness Impaired Hearing Ear Ringing Headaches Sinus Problems
Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

Respiratory:

Pneumonia Frequent Colds Difficulty Breathing Persistent Cough
Shortness of Breath Other Respiratory Problems: _____

Cardiovascular :

Heart Disease Chest pain Swelling of Hands or Feet High Blood Pressure
Palpitations/ Flutter Stroke Heart Murmurs Varicose Veins Rheumatic Fever
Other Cardiovascular Problems: _____

Gastrointestinal:

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Excess Gas
Heartburn Gallbladder Disease Liver Disease Hepatitis Hemorrhoids
Abdominal Pain Bloating Constipation Diarrhea Rectal Bleeding

Genito-Urinary:

Kidney Stones Kidney Disease Painful Urination Frequent Urination
Blood in Urine Frequent Urinary Infections Frequent Urination at Night

Menstrual/ Birthing History:

Irregular Cycle Breast Lumps/Tenderness Heavy Periods Vaginal Discharge
Menopausal Symptoms Premenstrual Problems Bleeding between Cycles Clotting
Painful Periods Infertility When was last Pap Smear? _____ Results: _____

Female Reproductive: Age of First Menses? _____ # Days of Menses: _____

Length of Cycle: _____ Birth Control Type: _____ # of Pregnancies: _____

of Miscarriages: _____ # of Live Births: _____ # of Abortions: _____

Male Reproductive:

Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

Musculoskeletal:

Neck/ Shoulder Pain Upper Extremity Pain Lower Extremity Pain Muscle Weakness

Back Pain: Upper Mid Lower Joint Pain : Where: _____

Neurologic :

Vertigo/Dizziness Paralysis Numbness/ Tingling Loss of Balance Seizures

Endocrine:

Hypothyroid Hyperthyroid Hypoglycemia Diabetes Night Sweats

Feeling Hot/Cold

Other:

Anemia Cancer Eczema/Hives Cold Hands/ Feet

Is there anything else we should know? _____

Lifestyle:

Do you typically eat at least three meals a day? Y N If no, how many? _____

Do you exercise? Y N If yes, how long/ how many days per week? _____ / _____

How many hours per night do you sleep? _____ Do you wake up during the night? Y N

Do you go back to sleep w/o problem? Y N Do you wake up rested? Y N

Occupation? _____ How many hours per week do you work? _____

Do you enjoy work? Y N Why/ Why not? _____

Nicotine/Alcohol/Caffeine/other Drug use: _____

Have you experienced any major trauma? Y N Explain: _____

How many glasses of non-caffeinated, non- carbonated beverages do you drink a day? _____

Interests/ Hobbies? _____

Stephanie Judge R.N., M.Ac., L.Ac. 443-540-3173