Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: ☐ M ☐ F	**Age:** _____	**DOB:** ____/____/____
Referred by:	**Dietician:**	
Primary Care Provider:	**Therapist/Counselor:**	
Other Medical Providers:	**Coach:**	

Please list reasons for seeking consultation at Seattle Performance Medicine and / or any goals you have related to

1.

2.

3.

PERSONAL HEALTH HISTORY

Illnesses (Check all that apply)			
☐ High Blood Pressure	Date/Yr.	☐ Hepatitis	Date/Yr.
☐ Coronary Artery or Heart Disease	Date/Yr.	☐ Gall Stones/Gall Bladder Surgery	Date/Yr.
☐ Cardiac Arrhythmia	Date/Yr.	☐ Irritable Bowel Syndrome (IBS)	Date/Yr.
☐ Heart Murmur	Date/Yr.	☐ Inflammatory Bowel Disease (Crohn's, UC)	Date/Yr.
☐ Tuberculosis (TB) or Positive PPD Test	Date/Yr.	☐ Gastric Reflux/GERD	Date/Yr.
☐ Asthma/ Bronchitis	Date/Yr.	☐ Ulcers	Date/Yr.
☐ Seasonal Allergies	Date/Yr.	☐ Urinary Tract Infection (Bladder or Kidney)	Date/Yr.
☐ Anemia	Date/Yr.	☐ Kidney Stones	Date/Yr.
☐ Blood Disease/Disorder	Date/Yr.	☐ Polycystic Ovarian Syndrome (PCOS)	Date/Yr.
☐ Deep Venous Thrombosis	Date/Yr.	☐ STI (warts, herpes, Chlamydia, Gonorrhea, Other)	Date/Yr.
☐ Cancer or Tumor; Type:	Date/Yr.	☐ Abnormal Pap Test	Date/Yr.
☐ Multiple Sclerosis	Date/Yr.	☐ HIV/AIDS	Date/Yr.
☐ Mononucleosis	Date/Yr.	☐ Depression	Date/Yr.
☐ Loss of Consciousness/ Head Injury	Date/Yr.	☐ Anxiety	Date/Yr.
☐ Seizures	Date/Yr.	☐ Eating Disorder	Date/Yr.
☐ Thyroid Disease	Date/Yr.	☐ Bipolar Disorder	Date/Yr.

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☐ Diabetes	Date/Yr.	☐ Obsessive Compulsive Disorder (OCD)	Date/Yr.
☐ Systemic Lupus Erythematosus (SLE)	Date/Yr.	☐ Overtraining Syndrome	Date/Yr.
☐ Rheumatoid Arthritis	Date/Yr.	☐ ADD/ADHD	Date/Yr.
☐ Other Autoimmune Disorder	Date/Yr.	☐ Alcohol/Substance Abuse	Date/Yr.
☐ Chronic Fatigue Syndrome	Date/Yr.	☐ Frequent HA/Migraines	Date/Yr.
☐ Skin Conditions/Rashes	Date/Yr.	☐ Fibromyalgia	Date/Yr.

List any other medical conditions not specified above:

1.
2.
3.

Surgeries

Year	Reason	Hospital

Other hospitalizations or treatment

Month/Year	Reason	Hospital

List ALL medications (please include prescriptions, over-the-counter medications, vitamins, supplements, herbal remedies, etc.)

Name of Drug	Strength	Frequency Taken	Start Date/Year	Prescribed By

Allergies to medications, foods, or others (latex, insect bites, environmental)

Name	Reaction

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HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Section	Question				
Occupation	Occupation:	Name of employer:			
	Hours per week:	Work stress level:			
	Have you missed any work due to your current health condition? ☐ No ☐ Yes Describe:				
Education	Are you currently a student:	Current grade/year of study:			
	Institution:	Focus of study (if applicable):			
	Highest level of education you have completed: ☐ High school ☐ College ☐ Graduate School ☐ Other:				
	Have you missed any school due to your current health condition? ☐ No ☐ Yes Describe:				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda	☐ Other
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?	☐ Yes	☐ No		
	How many drinks per week?				
	Do you ever drive or ride with a driver under the influence of alcohol or other substances?	☐ Yes	☐ No		
Tobacco	Current or past tobacco use?	☐ Yes	☐ No		
	Type(s):	# per day:	# of years:	Year quit:	
Recreational Drugs	☐ Never	☐ Past	☐ Present		
	Substance(s) used:				
Sex	Are you sexually active?	☐ Yes	☐ No		
	Are you currently using any form of protection against sexually transmitted infections?	☐ Yes	☐ No		
	Are you currently using any form of contraception to prevent pregnancy?	☐ Yes	☐ No		
Exercise	☐ I exercise regularly				
	☐ I am training for an event. Event:	How long have you consistently exercised?:			
	Please check all that you participate in: ☐ Run ☐ Walk ☐ Bike ☐ Swim ☐ Kayak ☐ Row ☐ Hike ☐ Cross/Elliptical Trainer				
	List other physical activities that you regularly participate in:				
	# of cardio workouts/week:	Intensity (high, med, low):	Duration:		
	# of strength workouts/week:	# of sets:	# of reps:		
Dietary	How would you describe your nutritional intake:				
	☐ Regular	☐ Diabetic	☐ Low Carbohydrate	☐ High Protein	
	☐ Vegetarian	☐ Vegan	☐ Low Fat	☐ Low Sodium	
	☐ Weight Reduction	☐ Weight Gain	☐ Lactose Free	☐ Gluten Free	
	☐ Other. Describe:				
	Number of meals in an average day:	Number of snacks in an average day:			
Safety	Have you ever been verbally, physically, emotionally, or sexually assaulted?	☐ Yes	☐ No		
	Do you currently feel safe in your home, school, and/or work environment(s)?	☐ Yes	☐ No		
	Do you always wear a seatbelt when driving/riding in a vehicle?	☐ Yes	☐ No		
	Do you always wear a helmet when bicycling, rollerblading or other activities at high risk for head injuries?	☐ Yes	☐ No		

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FAMILY HEALTH HISTORY

Pertains to biologic relatives (Parents, grandparents, siblings, aunts, uncles etc.) who have the following diseases.			
Alcohol/Drug Abuse		High Blood Pressure	
Asthma		Intestinal Disorder	
Bleeding Disorder		Kidney Disease	
Blood Clots		Mental Illness	
Cancer		Migraine Headaches	
Depression		Neurologic Disorder	
Diabetes		Premature Death	
Eating Disorder		Stroke	
Gynecologic Problems		Suicide Attempt	
Heart Disease/Attack		Thyroid Disease	
High Cholesterol		Other	

HEALTH MAINTENANCE

Provide date of most recent exams/procedures (if applicable):			
Physical Exam:	Colonoscopy:	Sigmoidoscopy:	Mammogram:
Blood Work:	Pap (women):	Prostate (men):	DEXA/Bone Density:
EKG:	Cardiac Stress Test:	Heart Scan:	Tetanus Booster:

WOMEN ONLY

Age at onset of menstruation:		Date of last menstruation:	

Average period occurs every _____ days and lasts approximately _____ days.

Question		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Do you perform monthly self-breast examinations?		

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MEN ONLY

Question	Yes	No
Do you usually get up to urinate frequently during the night?	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased or do you have problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No

REVIEW OF SYSTEMS

CHECK IF YOU HAVE, OR CURRENTLY EXPERIENCE ANY SYMPTOMS IN THE FOLLOWING AREAS TO A SIGNIFICANT DEGREE.

System				
General	☐ Loss of Appetite	☐ Fever or Chills	☐ Mental fogginess	☐ Fatigue
	☐ Insomnia	☐ Sweats	☐ Weight Gain	☐ Weight Loss
Eyes	☐ Blurred Vision	☐ Double vision	☐ Eye Pain	☐ Eye Discharge
	☐ Vision Loss	☐ Eye Irritation/Itching	☐ Glasses	☐ Contacts
Ears, Nose and Throat	☐ Decreased Hearing	☐ Ringing in Ears	☐ Ear Pain	☐ Hoarseness
	☐ Pain Swallowing	☐ Nose Bleeds	☐ Dental Devices	☐ Brush & Floss Daily
Cardiovascular	☐ Chest Pain at Rest	☐ Chest Pain with Activity	☐ Peripheral Edema	☐ Palpitations
Respiratory	☐ Cough	☐ Wheezing	☐ Shortness of Breath	☐ Bloody Sputum
Gastrointestinal	☐ Abdominal Pain	☐ Nausea	☐ Vomiting	☐ Diarrhea
	☐ Constipation	☐ Bloody or Dark Stool	☐ Blood in Vomit	☐ Reflux/ Heartburn
Genitourinary	☐ Painful Urination	☐ Blood in Urine	☐ Difficulty Urinating	☐ Incontinence
	☐ Frequent Urination	☐ Change in Urine Color	☐ Increased Night Urination	
Musculoskeletal	☐ Back Pain	☐ Joint Pain	☐ Joint Swelling	☐ Muscle Weakness
	☐ Muscle Twitching	☐ Muscle Aches	☐ Broken Bones	☐ Stress Fractures
Skin	☐ Dry Skin	☐ Itching	☐ Rash	☐ Suspicious Lesions
	☐ Acne	☐ Unwanted Hair Growth		
Neurological	☐ Dizziness	☐ Weakness	☐ Tremors	☐ Numbness
Psychiatric	☐ Depression	☐ Anxiety	☐ Self Harm Behavior	☐ Suicidal Thoughts
Endocrine	☐ Cold Intolerance	☐ Heat Intolerance	☐ Increased Thirst	☐ Weight Change
Hematologic/ Lymphatic	☐ Abnormal Bruising	☐ Easy Bleeding	☐ Enlarged Lymph Nodes	

CERTIFICATION

The above information is true to the best of my knowledge.

X ______________________________________ ______________
Patient (Signature) Date

X ______________________________________ ______________
Legal Guardian/Authorized Individual Signature (Required if under 18 years of age) Date

Staff: The above health history questionnaire was reviewed by ________________ (physician) on ________ (date).

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