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:** / /
Please list any health and/or fitness goals:			
1. 2. 3.			

PERSONAL HEALTH HISTORY	
Illnesses (Check any that apply)	
☐ High Blood Pressure	☐ Hepatitis B or C
☐ Coronary Artery or Heart Disease	☐ Gall Stones/Gall Bladder Surgery
☐ Cardiac Arrhythmia (irregular heart rhythm)	☐ Irritable Bowel Syndrome (IBS)
☐ Heart Murmur	☐ Inflammatory Bowel Disease (Crohn's, UC)
☐ Heart Valve Abnormality	☐ Gastric Reflux/GERD
☐ Asthma/ Bronchitis	☐ GI Ulcer (esophageal, gastric or duodenal)
☐ Seasonal Allergies	☐ Frequent Urinary Tract Infections (Bladder or Kidney)
☐ Anemia	☐ Kidney Stones
☐ Blood Disease/Disorder	☐ Multiple Sclerosis
☐ Deep Venous Thrombosis	☐ Cancer or Tumor; Type:
☐ Fibromyalgia	☐ Depression
☐ Loss of Consciousness/ Head Injury	☐ Anxiety
☐ Seizures	☐ Eating Disorder
☐ Thyroid Disorder (hypothyroid, hyperthyroid, Hashimoto's or Graves)	☐ Bipolar Disorder
☐ Diabetes Type 1 (last HBA1C =)	☐ Obsessive Compulsive Disorder (OCD)
☐ Diabetes Type 2 (last HBA1C =)	☐ Overtraining Syndrome
☐ Systemic Lupus Erythematosus (SLE)	☐ ADD/ADHD
☐ Rheumatoid Arthritis	☐ Alcohol/Substance Abuse
☐ Chronic Fatigue Syndrome	☐ Frequent Severe Headaches/Migraines

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List any other medical conditions not specified above:
1. 2. 3.

Surgeries / Hospitalizations or Inpatient treatment		
Year	Reason	Hospital

List <u>ALL</u> medications (include prescriptions, <u>over-the-counter medications</u>, <u>vitamins</u>, <u>supplements</u>, <u>herbal remedies</u>, etc.)				
Name of Drug / Supplement	Strength (mg, etc)	Times per Day	Start Date/Year	Prescribed By
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	

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

HEALTH HABITS AND PERSONAL SAFETY

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

Occupation	Occupation:		Name of employer:
	Hours per week:		Work stress level: (high, medium, low)
Caffeine **Alcohol, Tobacco**	# of cups/cans per day? # drinks per week? Current or past tobacco use (circle) – how many years smoked when quit:		
Exercise **Exercise**	☐ I exercise regularly ☐ I am training for an event. Event:	How long have you consistently exercised? months / years (circle)	Please check all that you participate in: ☐ Run ☐ Walk ☐ Bike ☐ Swim ☐ Kayak ☐ Row ☐ Hike ☐ Cross/Elliptical Trainer ☐ Other Activity: ,
	# of cardio workouts/week:		Intensity (high, med, low): Duration: - minutes/session
	# of strength workouts/week:		# of sets: # of reps:

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Dietary	How would you describe your nutritional intake: # meals/day #snacks/day			
	☐ Regular	☐ Diabetic	☐ Low Carbohydrate	☐ High Protein
	☐ Weight Reduction	☐ Vegan	☐ Low Fat	☐ Low Sodium
	☐ Other	☐ Weight Gain	☐ Lactose Free	☐ Gluten Free

FAMILY HEALTH HISTORY

List which biologic relatives (Parents, grandparents, siblings, aunts, uncles etc.) 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:	Colon screening:	EKG:	Blood Work:
Cardiac Stress Test:	Pap (women):	Mammogram (women):	DEXA/Bone Density:
Heart Scan:	Chest X-Ray:		Tetanus Booster:

WOMEN ONLY

Age at onset of menstruation:		Date of last menstruation:	

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

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?	☐ Yes	☐ No

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MEN ONLY		
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 CURRENTLY EXPERIENCE ANY SYMPTOMS IN THE FOLLOWING AREAS TO A SIGNIFICANT DEGREE.

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 mole
	☐ 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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