



Institute of Complementary Medicine

Today's Date:

INITIAL HEALTH HISTORY QUESTIONNAIRE

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

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------|
| Name (Last, First, M.I.): | <input type="checkbox"/> M | <input type="checkbox"/> F | Date of Birth: |
| Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | | |
| Number of children: | | Age Range of Children: | |
| Previous or referring doctor: | | | |
| Reason for visit: | | | |

PERSONAL HEALTH HISTORY

List all medications and supplements taken regularly

| Name the Drug or Supplement | Taken for: | Dose (strength and frequency) | Prescribed by: (write "Self" if self-prescribed) |
|-----------------------------|------------|-------------------------------|--------------------------------------------------|
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Do you have any known allergies to medications? Yes No If yes, please fill out chart below.

| Name the Drug | Reaction You Had |
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Childhood illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio Other:

Immunizations: (Please indicate dates.)

| | |
|---------------------------------------|-------------------------------------------------------------------------|
| <input type="checkbox"/> Tetanus: | <input type="checkbox"/> Pneumonia: |
| <input type="checkbox"/> Hepatitis A: | <input type="checkbox"/> Chickenpox: |
| <input type="checkbox"/> Hepatitis B: | <input type="checkbox"/> HPV: |
| <input type="checkbox"/> Influenza: | <input type="checkbox"/> MMR: <small>Measles, Mumps, Rubella</small> |

Screening Exams: Please indicate the date of your last exam and whether it was normal.

| Exam | Date | Result | Exam | Date | Result |
|---------------------|------|-------------------------------------------------------------------|--------------------------|------|-------------------------------------------------------------------|
| Cholesterol | | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Hemoccult/Blood in stool | | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| Colonoscopy | | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Mammogram (women) | | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| DEXA/Bone Scan | | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | PAP (women) | | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| Dental | | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Physical Exam | | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| Eye Exam | | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Prostate (men) | | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| Glucose/Blood Sugar | | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | TB Screening | | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |

Please print, fill in, and bring with you for your office visit

| Hospitalizations | | Surgeries | |
|------------------|--------|-----------|--------|
| Year | Reason | Year | Reason |
| | | | |
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List any medical problems that other doctors have diagnosed

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FAMILY HEALTH HISTORY

Please place an "X" in the relevant boxes.

| Condition: | Mother | Father | Sibling | Grandparent (maternal) | Grandparent (paternal) |
|-----------------------|--------|--------|---------|------------------------|------------------------|
| Alcoholism | | | | | |
| Autoimmune | | | | | |
| Cancer (specify type) | | | | | |
| Diabetes | | | | | |
| Heart Disease | | | | | |
| High cholesterol | | | | | |
| Hypertension | | | | | |
| Mental Illness | | | | | |
| Migraine | | | | | |
| Multiple Sclerosis | | | | | |
| Osteoporosis | | | | | |
| Seizures | | | | | |
| Stroke | | | | | |
| Thyroid | | | | | |

HEALTH HABITS AND PERSONAL SAFETY

| | | | | |
|-----------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--|
| Alcohol | Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, indicate type and how many drinks per week: | | |
| | Are you concerned about the amount you drink? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Have you considered stopping? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Have you ever experienced blackouts? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Are you prone to "binge" drinking? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Do you drive after drinking? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Caffeine | <input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola/Soda | | | |
| | # of cups/cans per day? | | | |
| Diet | Do you follow a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, specify: | | |
| | Do you avoid any foods? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, specify: | | |
| | How much water do you drink per day? | | Is it filtered water? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes | |
| | Please list the typical foods you eat for: | | | |
| | Breakfast: | | | |
| | Lunch: | | | |
| Dinner: | | | | |
| Snacks: | | | | |

Please print, fill in, and bring with you for your office visit

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|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| Exercise | <input type="checkbox"/> Sedentary (No exercise) | | |
| | <input type="checkbox"/> Mild exercise (for example, climbing stairs, walking 3 blocks, golf) | | |
| | <input type="checkbox"/> Occasional vigorous exercise (for example, work or recreation, less than 4x/week for 30 min.) | | |
| | <input type="checkbox"/> Regular vigorous exercise (for example, work or recreation 4x/week for 30 minutes or more) | | |
| Sleep | Do you have trouble falling asleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you wake during the night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | If yes, do you have trouble falling back asleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you wake feeling rested? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Average number of hours of sleep: | | |
| | Rate your current energy on a scale of 1-10 (10=highest): | | |
| Tobacco | Do you use tobacco? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Cigarettes or other form – amt./day: # of years: Or year quit: | | |
| Drugs | Do you currently use recreational or street drugs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Have you ever given yourself street drugs with a needle? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sex | Are you currently sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No Gender of sexual partner(s): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Both | | |
| | Have you been sexually active in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Gender of sexual partner(s): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Both | | |
| | Are you trying for a pregnancy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | If you are not trying for a pregnancy, list contraceptive or barrier method used: | | |
| | Any problems or concern with sexual function or desire? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Illness related to Human Immunodeficiency Virus (HIV), such as AIDS, have become a major public health problem. Risk factors for this illness include IV drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Personal Safety | Do you live alone? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you have frequent falls? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you have vision or hearing loss? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you wear your seat belt? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you wear your helmet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you avoid excess UV exposure or wear sunscreen? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Is the battery current in your smoke detector? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you have an Advance Directive or Living Will? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Would you like information on the preparation of an Advanced Directive or Living Will? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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| MENTAL HEALTH | | |
| Is stress a major problem for you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel depressed or cry frequently? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you panic when stressed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have problems with eating or your appetite? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you intentionally harmed yourself? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever seriously thought about hurting yourself? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever seriously thought about hurting others? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel you have an adequate support system? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you currently seeing a counselor? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who? | | |

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| Review of systems: Mark "C" for current problems; For problems in the past, please write the YEAR it occurred. | | | | | |
|-----------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------|------------------------------------------|------------------------------------|-------------------------------|
| Current? Past? (Write Date) | Allergic/Immunologic | Current? Past? (Write Date) | Ears, Nose, Mouth, Throat (cont.) | Current? Past? (Write Date) | Hematological |
| | Arthritic flare-up | | Epistaxis (nosebleeds) | | Anemia |
| | Hay fever symptoms | | Hoarseness | | Bruise Easily |
| | Cardiovascular | | Hypoglycemia | | Musculoskeletal |
| | Ankle swelling | | Ringing in ear | | Back pain (chronic) |
| | Chest pain | | Sinus problem | | Foot pain |
| | Elevated blood pressure | | Sore throat | | Gout attack |
| | Fatigue | | Eyes | | Leg pain |
| | Irregular heartbeat | | Blurred Vision | | Neck pain |
| | Murmur (heart) | | Loss of vision | | Neurological |
| | Palpitations | | Pain or soreness in or about the eyes | | Difficulty concentrating |
| | Shortness of breath at rest | | Gastrointestinal | | Dizziness |
| | Shortness of breath in the night | | Abdominal pain | | Headache |
| | Shortness of breath with exercise | | Blood in stool | | Numbness |
| | Syncope (fainting) | | Constipation | | Seizures |
| | Varicose veins | | Diarrhea | | Tingling |
| | Dermatologic (Skin) | | Heartburn | | Tremors |
| | Eczema | | Hemorrhoids | | Psychiatric |
| | Hives | | Loss of appetite | | Anxiety |
| | Pruritis (itching) | | Melena (dark, tarry stools) | | Depression |
| | Psoriatic flare-up | | Nausea | | Insomnia |
| | Rash | | Swallowing difficulty | | Memory Loss |
| | Endocrine | | Vomiting | | Mood changes |
| | Cold intolerance | | Weight gain | | Respiratory |
| | Dry Skin | | Weight loss, unintentional | | Asthma |
| | Excess hair growth | | Yellowing of skin | | Cough |
| | Extreme thirst | | Genitourinary | | Wheezing |
| | Hyperglycemia | | Discharge (from urethra) | | Shortness of breath |
| | Thyroid disease | | Painful urination | | |
| | Unusual fatigue | | Urinary difficulty | | Other? Please explain: |
| | Ears, Nose, Mouth, Throat | | Urinary incontinence | | |
| | Cough, chronic | | Urinary output low | | |
| | Difficulty with hearing | | Urinating frequently at night | | |
| | Ear infection | | | | |

Please print, fill in, and bring with you for your office visit

| WOMEN ONLY | | |
|-------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| Age at onset of menstruation: | | |
| First day of last menstrual period: ____/____/____ | Number of days of flow: | |
| Period every ____ days | | |
| Heavy periods, irregularity, spotting, pain, or discharge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Number of pregnancies ____ Number of live births ____ Number of Miscarriages ____ | | |
| Are you pregnant or breastfeeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any urinary tract, bladder, or kidney infections within the last year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any blood in your urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any problems with control of urination? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any hot flashes or sweating at night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you been instructed on breast self-exams? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you regularly do breast self-exams? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| MEN ONLY | | |
|-------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| Do you usually get up to urinate during the night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, # of times ____ | | |
| Do you feel pain or burning with urination? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any blood in your urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel burning discharge from penis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has the force of your urination decreased? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any problems emptying your bladder completely? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any difficulty with erection or ejaculation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any testicle pain or swelling? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you been instructed on testicular self-exams? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you regularly do testicular self-exams? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |