

INITIAL HEALTH HISTORY QUESTIONNAIRE

Name	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> T	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Blood Type:	
Number of Children:	Names/ages:	

CURRENT HEALTH CONCERNS

Concern #1:	Date of Onset:
Describe:	

Concern #2:	Date of Onset:
Describe:	

Concern #3:	Date of Onset:
Describe:	

Patient Name: _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug/Supplement	Strength	Frequency Taken

Allergies to medications/supplements	
Name the Drug/supplement	Reaction You Had

Surgeries & Hospitalizations	
Year	Reason

SOCIAL HEALTH HISTORY

Exercise	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?				
	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

Patient Name: _____

Tobacco	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> Cigars - #/day	<input type="checkbox"/> # of years <input type="checkbox"/> 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 sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, are you trying for a pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No		

FAMILY HEALTH HISTORY UNKNOWN/ADOPTED

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

GENERAL INFORMATION

Have you ever seen a Naturopathic Physician before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, please indicate Doctor's name:		
Do you see other healthcare practitioners (i.e. acupuncturist, massage therapist, counselor)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, please indicate which ones:		
Have you had a physical in the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, approximate date:		
Have you had bloodwork done in the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, approximate date:		
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, name of counselor:		

Patient Name: _____

WOMEN ONLY

Age at onset of menstruation:		
Date of beginning of last menstrual cycle:		
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 ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<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 PMS symptoms?	<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
Date of last pap and rectal exam?		

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
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

REVIEW OF SYSTEMS/OTHER CONCERNS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	