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WHOLENESS 123

HEALTH HISTORY QUESTIONAIRE

Name ____ **Date** __________________________

Chief Concern____
____

Other Concerns ____
____
____

When did these problems begin? (Be Specific) ____
____
____

How do these complaints affect your daily activities? (work, sleep, relationships) __________________
____
____

Have you been diagnosed? If so, what is the diagnosis? _______________________________________
____

What kinds of treatments have you tried? ____
____

Are you Pregnant? _______________________ **Do you have a pacemaker?** _______________________

Medical History for the past six (6) months (include dates) ____________________________________
____

(over)

Family Medical History & significant illness (please circle) Cancer Diabetes Hepatitis
Heart Disease High Blood Pressure Stroke Rheumatic Fever Seizures Thyroid Disease
Venereal Disease Allergies Asthma Other____

Surgeries ____

____

____

Significant Trauma (auto accidents, injuries, etc.) ____

____

____

Your Birth History (prolonged labor, forceps delivery, etc.) ___________________________________

____

Allergies (drugs, chemicals, foods) ____

____

Medications taken in the last two (2) months (include vitamins, drugs, herbs, birth control and over the counter) ____

____

____

Lifestyle / Occupational Stress (chemical, physical etc.) ____

____

Do you exercise? ____________ **How Regularly**? ____________ **Describe** _______________________

____

Have you ever been on a restricted diet? ______________ **What Kind**? ___________________________

____

Please describe your average daily diet including meals and snacks:

Morning: ____

____

Afternoon:____

____

Evening: ____

____

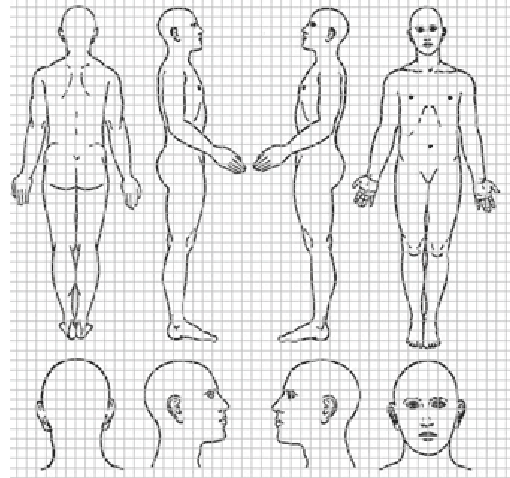
Is there anything else you would like us to know about you? ___________________________________

____

____

(over)

Indicate any painful or distressed areas



Please check if you have had within the last three (3) months:

____ Poor appetite
____ Fevers
____ Sweats easily
____ Localized weakness
____ Peculiar tastes or smells
____ Sudden thirst (cold or hot drinks)
_____ Poor sleeping
_____ Chills
_____ Tremors
_____ Poor balance
_____ Weight loss
_____ Fatigue
_____ Night sweats
_____ Cravings
_____ Change in appetite
_____ Weight gain

Sudden energy drop (what time of day?) ____

SKIN and HAIR

____ Rashes
____ Itching
____ Dandruff
____ Change in hair or skin texture
_____ Ulcerations
_____ Eczema
_____ Loss of hair
_____ Hives
_____ Pimples
_____ Recent moles

Any other hair or skin problems? ____

(over)

HEAD, EYES, EARS, NOSE and THROAT

____ Dizziness
____ Glasses
____ Poor Vision
____ Cataracts
____ Ringing in ears
____ Sinus problems
____ Grinding teeth
____ Teeth problems
_____ Concussions
_____ Eye strains
_____ Night blindness
_____ Blurry vision
_____ Poor hearing
_____ Nose bleeds
_____ Facial pain
_____ Jaw clicks
_____ Migraines
_____ Eye pain
_____ Color blindness
_____ Earaches
_____ Spots in front of eyes
_____ recurrent sore throats
_____ Sores on lips or tongue

HEADACHES? Where and when?____

Any other head and / or neck problems? ____

CARDIOVASCULAR

_____ High blood pressure
____ irregular heartbeat
____ Cold hands or feet
____ Blood clots
_____ Low blood pressure
_____ dizziness
_____ swelling of hands
_____ Phlebitis
_____ Chest pain
_____ Fainting
_____ Swelling of feet
_____ Difficulty breathing

ANY OTHER HEART OR BLOOD VESSEL PROBLEMS?_____________________________________
____

RESPIRATORY

____ Cough
____ Bronchitis
_____ Coughing blood
_____ Pneumonia
_____ Asthma
_____ Pain with deep breath
____ Difficulty breathing when lying down
____ Production of Phlegm What color?_____________

Any other lung problem? ____

GASTROINTESTINAL

_____ Nausea
____ Constipation
____ Black stools
____ bad breath
____ Chronic laxative use
_____ Vomiting
_____ Gas
_____ Blood in stools
_____ Rectal pain
_____ Diarrhea
_____ Belching
_____ Indigestion
_____ Hemorrhoids

Any other problems with your stomach or intestines?____

(over)

GENITO-URINARY

____ Pain on urination
_____ frequent urination
_____ Blood in urine
____ Urgency to urinate
_____ unable to hold urine
_____ Kidney stones
____ decrease in flow
_____ impotency
_____ Sores on genitals

Do you wake up to urinate? How often? ____

Any particular color to your urine? ____

Any other problems with your genitals or urinary system? _____________________________

PREGNANCY & GYNOCOLOGY

____ Number of pregnancies
_____ Number of births
_____ Premature birth
____ Miscarriages
_____ Abortions
_____ Age @ first menses
____ Period between menses
_____ Duration
_____ first day of last menses
____ Unusual character (heavy or light)
_____ Irregular periods
____ Painful periods
_____ Clots
_____ Last PAP
____ Vaginal discharge
_____ Vaginal sores
_____ Breast lumps
____ Changes to body / psyche prior to discharge

Do you practice birth control?____ What type and for how long?__________________________

MUSCULOSKELATAL

____ Neck pain
_____ Muscle pains
_____ Knee pains
____ back pain
_____ Muscle weakness
_____ Foot/ankle pains
____ Hand/wrist pains
_____ Shoulder pain
_____ Hip pain

ANY OTHER JOINT OR BONE PROBLEMS? ______________________________________

NEUROPSYCHOLOGICAL

____ Seizures
_____ Dizziness
_____ Loss of balance
____ Areas of numbness
_____ Lack of coordination
_____ Poor memory
____ Concussion
_____ Depression
_____ Anxiety
____ Bad temper
_____ Easily susceptible to stress

Have you ever been treated for emotional problems?______________________________

Have you ever considered or attempted suicide? __________________________________

Any other neurological or psychological problems? ______________________________

COMMENTS:

(over)