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Florida Board of Health License#: AP 2051

## Health History Questionnaire

*\*Please use the reverse of these sheets if needed for more detailed information.*

*\*Please bring copies of relevant labs, test results/reports, etc. to your initial visit.*

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: (M/F) \_\_\_\_\_ What is your age today? \_\_\_\_\_

Phone Numbers (Home, Work, Cell): \_\_\_\_\_

\*Is it OK to leave messages? Yes / No Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Where else have you lived? \_\_\_\_\_

Place of employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital status: \_\_\_\_\_ Partner's name: \_\_\_\_\_ # of Children \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Were you referred by anyone? \_\_\_\_\_

**What is your main concern today? Have you been given a Western Medical diagnosis? (describe)**

\_\_\_\_\_  
\_\_\_\_\_

When did this issue begin? What do you feel was the cause of this issue? Is the cause still present?  
(Please be specific) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What treatments have you tried? What other types of practitioners have you seen? What were the results? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How would your life be different if this concern were no longer present? What would your life look like? What would you do differently? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What is the intensity of your concern right now? Please rate on a scale of 1-10, 1=barely notice 10=unbearable.

1    2    3    4    5    6    7    8    9    10

What makes your condition better? \_\_\_\_\_

What makes your condition worse? \_\_\_\_\_

Have you noticed any other correlations (i.e. changes with weather, stress, emotions)? \_\_\_\_\_

Are there other concerns you would like to focus on with treatment? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient's Name: \_\_\_\_\_

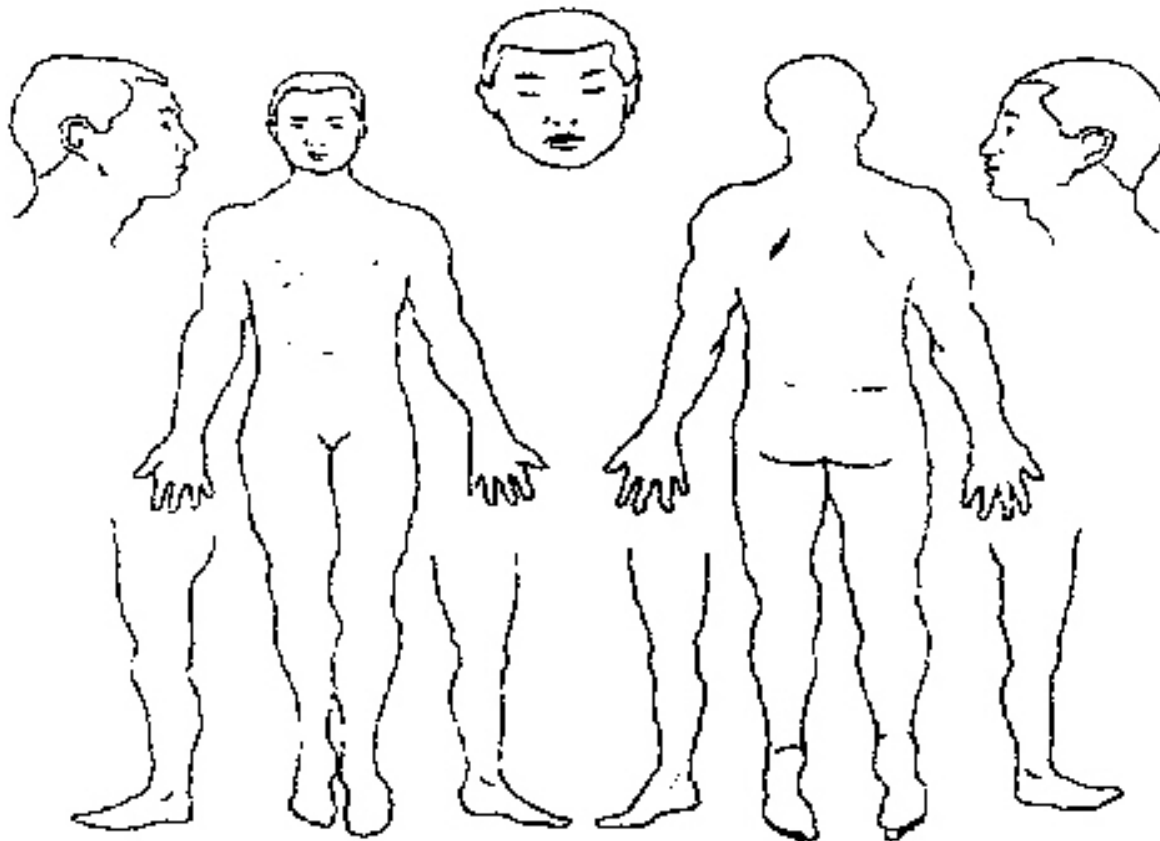
Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE INDICATE AREAS OF CONCERN OR PAIN BY CIRCLING THE DIAGRAM BELOW**

Please indicate the intensity of your concern or pain by rating on a scale of 1-10: 1=barely notice to 10=unbearable.

Please indicate the nature of the pain or discomfort with the following:

Stabbing Pain = SP, Tension & Tightness = T, Numbness = N, Dull Pain = DP, Burning = B, Ache = A



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Primary Care Physician: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_ Significant Results: \_\_\_\_\_

Specialists \_\_\_\_\_

- What are your treatment goals?
- Temporary relief of symptoms/pain control
  - Eliminate root or cause problem (if possible)
  - Maintenance care (periodic balancing tune-up to maintain wellness and health)
  - Other: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PATIENT'S PAST MEDICAL HISTORY:** \*Please use the reverse of this sheet if needed for more detailed information.

Have you ever tested **positive** for: Hepatitis: Yes No Type: \_\_\_\_\_ OR HIV/AIDS: Yes No

Surgeries & Hospitalizations (type & dates) \_\_\_\_\_

Significant Illness (Please indicate if you have been diagnosed with any of the following; include dates):  Cancer \_\_\_\_\_

High Blood Pressure \_\_\_\_\_  Rheumatic Fever \_\_\_\_\_  Sexually Transmitted Disease \_\_\_\_\_  Diabetes \_\_\_\_\_

Heart Disease \_\_\_\_\_  Seizures \_\_\_\_\_  Asthma \_\_\_\_\_  Stroke \_\_\_\_\_  Pacemaker \_\_\_\_\_

Thyroid Disease (hypo/hyper) \_\_\_\_\_  Other \_\_\_\_\_

Significant Physical Trauma (auto accidents, falls, dental work, etc.): \_\_\_\_\_

Significant Emotional Trauma (divorce, death, job change, etc.): \_\_\_\_\_

Occupational Stress (chemical, physical, psychological, etc.): \_\_\_\_\_

Allergies (drugs, chemicals, animals, etc.), Please describe what reactions you have to allergens: \_\_\_\_\_

**CURRENT PRESCRIPTION MEDICATIONS:**

Name of Medication	Condition treating	Date prescribed

Please list significant prescription medication use in the past (please include antibiotic history): \_\_\_\_\_

**SUPPLEMENTS, HERBS, VITAMINS, OVER THE COUNTER MEDICATIONS:**

Name	Condition treating	Duration of use

**FAMILY MEDICAL HISTORY:** (Please check all that apply)

- |  |                                     |  |   |
|--|-------------------------------------|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer (specify type below) | <input type="checkbox"/> Allergies (specify type below) |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Seizures   | _____  | _____   |
| <input type="checkbox"/> Arteriosclerosis    | <input type="checkbox"/> Asthma     | _____  | _____   |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Diabetes   | _____  | _____   |
| <input type="checkbox"/> Other: _____        |                                     |  |   |

**Please check any of the following symptoms that are relevant to your health history.**

General	Head, Eyes Ears Nose & Throat	Cardiovascular	Gastrointestinal
<input type="checkbox"/> Chills <input type="checkbox"/> Fevers <input type="checkbox"/> Sweat easily <input type="checkbox"/> Night sweats <input type="checkbox"/> Localized weakness <input type="checkbox"/> Bleed or Bruise easily <input type="checkbox"/> Peculiar taste in mouth <input type="checkbox"/> Strong thirst (cold or hot) <input type="checkbox"/> No desire to drink <input type="checkbox"/> Fatigue <input type="checkbox"/> Sudden drop in energy Time of day: _____ <input type="checkbox"/> Edema Location: _____ <input type="checkbox"/> Trouble falling asleep <input type="checkbox"/> Trouble staying asleep <input type="checkbox"/> Tremors <input type="checkbox"/> Poor balance <input type="checkbox"/> Cravings <input type="checkbox"/> Change in appetite <input type="checkbox"/> Weight change Gain / Loss; Amount _____	<input type="checkbox"/> Dizziness <input type="checkbox"/> Migraines <input type="checkbox"/> Headaches When: _____ Where: _____ <input type="checkbox"/> Facial Pain <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Poor vision Distance / Reading (circle) <input type="checkbox"/> Night blindness <input type="checkbox"/> Blurry vision <input type="checkbox"/> Floaters / spots in vision <input type="checkbox"/> Color blindness <input type="checkbox"/> Eye pain <input type="checkbox"/> Eye strain <input type="checkbox"/> Cataracts <input type="checkbox"/> Eye dryness <input type="checkbox"/> Excessive tearing <input type="checkbox"/> Discharge from eyes <input type="checkbox"/> Poor hearing <input type="checkbox"/> Ringing in ears High or Low pitch? <input type="checkbox"/> Earaches <input type="checkbox"/> Discharge from ears <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sinus congestion <input type="checkbox"/> Nasal drainage <input type="checkbox"/> Grinding teeth <input type="checkbox"/> Teeth problems <input type="checkbox"/> Jaw clicks / popping <input type="checkbox"/> Concussions <input type="checkbox"/> Recurrent sore throats <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sores on lips / tongue	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chest discomfort / pain <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Swelling of hands <input type="checkbox"/> Swelling of feet <input type="checkbox"/> Blood clots <input type="checkbox"/> Fainting <input type="checkbox"/> Difficulty breathing <p style="text-align: center;"><b>Respiratory</b></p> <input type="checkbox"/> Cough <input type="checkbox"/> Asthma/wheezing <input type="checkbox"/> Difficulty breathing Lying down / Exertion <input type="checkbox"/> Phlegm Color? _____ <input type="checkbox"/> Coughing blood <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis <p style="text-align: center;"><b>Genitourinary</b></p> <input type="checkbox"/> Pain on urination <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Decrease flow <input type="checkbox"/> Dribbling <input type="checkbox"/> Kidney stones <input type="checkbox"/> Impotency <input type="checkbox"/> Change in sex drive <input type="checkbox"/> Sores on genitals <input type="checkbox"/> Wake to urinate in the night (# times) _____ Urine color: _____	<input type="checkbox"/> Bad breath <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Heartburn <input type="checkbox"/> Belching <input type="checkbox"/> Indigestion <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Chronic laxative use <input type="checkbox"/> Blood in stools bright red <input type="checkbox"/> Abdominal pain / cramps <input type="checkbox"/> Gas <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Hemorrhoids <p style="text-align: center;"><b>Musculoskeletal</b></p> <input type="checkbox"/> <b>Pain:</b> <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Hip <input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Knee <input type="checkbox"/> Foot / Ankle <input type="checkbox"/> Hand / Wrist <input type="checkbox"/> Muscle pain / weakness <p style="text-align: center;"><b>Neuropsychological</b></p> <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness/ weakness <input type="checkbox"/> Vertigo <input type="checkbox"/> Bad temper <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety / easily stressed <input type="checkbox"/> Poor memory <input type="checkbox"/> Loss of balance <input type="checkbox"/> Violence potential <input type="checkbox"/> Sleep disorder <input type="checkbox"/> Lack of coordination

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### DIET AND LIFESTYLE

Do you have any known or suspected food allergies or sensitivities? (please be specific) \_\_\_\_\_

Please give a general description of the food you eat during a "typical" day.

Morning: \_\_\_\_\_

Afternoon: \_\_\_\_\_

Evening: \_\_\_\_\_

Before Bed: \_\_\_\_\_

Between Meals: \_\_\_\_\_

Are you now, or have you ever been on a restricted diet? Please describe diet and approximate dates: \_\_\_\_\_

Are you **MORE** than 20% **OVER** or  Are you **MORE** than 20% **LESS** your ideal body weight? Yes / No

Have you been exposed to any known environmental toxins or hormones? Yes / No If yes, what? \_\_\_\_\_

Do you drink milk processed with antibiotics or growth hormones? Yes / No

Do you eat chicken or meat that has been treated with antibiotics or growth hormones? Yes / No

How often do you have bowel movement (s) per day? \_\_\_\_\_ or per week? \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_

How many caffeinated drinks per day? \_\_\_\_\_ Type of drinks: \_\_\_\_\_

Do you drink alcohol? Yes / No If yes, would you describe yourself as a daily social weekend or occas. drinker

How much alcohol do you drink per **DAY** during the **week**? Hard Liquor (type & #): \_\_\_\_\_

Beer: \_\_ bottles/cans Wine (red white) \_\_glass (es) \_\_ bottles

How much alcohol do you drink per **DAY** on a **weekend**? Hard Liquor (type & #): \_\_\_\_\_

Beer: \_\_ bottles/cans Wine (red white) \_\_glass (es) \_\_ bottles

Are you presently taking steroids for any reason? Yes / No If yes, what are taking and why? \_\_\_\_\_

Please describe your past or present recreational drug use (if any): \_\_\_\_\_

How many cigarettes or packs do you smoke a day? \_\_\_\_ For how many years? \_\_\_\_ Have you quit? (when) \_\_\_\_

Do you believe you have or have had any problem with substance abuse? Yes / No Describe: \_\_\_\_\_

Have you ever seen a mental health professional? Yes / No If yes, who did you see and for what purpose: \_\_\_\_\_

Do you exercise regularly? Yes / No Please describe: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**GYNECOLOGICAL HISTORY**

# of Pregnancies (dates): \_\_\_\_\_

# of Births (dates): \_\_\_\_\_

# of Miscarriages (dates): \_\_\_\_\_ # of Abortions (dates): \_\_\_\_\_

**Menstrual History**

Menopause (If yes, please answer menses questions for history information) Last menses start date: \_\_\_\_\_

Menopausal onset (age) & symptoms if applicable: \_\_\_\_\_

Age at first Menses: \_\_\_\_\_ Length of full cycle (days between menses i.e. 24, 28, 32, ...): \_\_\_\_\_

Length of menses/flow: \_\_\_\_\_ (# of heavy days \_\_\_\_\_ # of light days \_\_\_\_\_ # of days spotting \_\_\_\_\_)

Do you experience spotting  before menses # of days \_\_\_\_\_ or  after menses # of days \_\_\_\_\_ color \_\_\_\_\_

Heavy Flow (How often do you change tampon/pad in day)? \_\_\_\_\_ Blood color: \_\_\_\_\_

Light Flow (How often do you change tampon/pad in day)? \_\_\_\_\_ Blood color: \_\_\_\_\_

Irregular periods (variable, short, long, missed) please explain: \_\_\_\_\_

Painful periods, please describe: \_\_\_\_\_

Changes in body/psyche prior to menstruation \_\_\_\_\_

Clots large/small  Scanty or missed periods  Excessive irritability ( before  during or  after menses)

**Have you experienced any of the following?**

Endometriosis  Uterine Fibroids  Ovarian cysts  Polycystic Ovarian Disease

Post-coital bleeding  Vaginal sores  Vaginal dryness  Vaginal Irritation

Abnormal Vaginal discharge: Color: \_\_\_\_\_ Consistency: \_\_\_\_\_ Odor: \_\_\_\_\_

Yeast Infections  Normal stretchy egg white discharge at time of ovulation  Urinary Tract Infections

Sexually transmitted diseases: \_\_\_\_\_

Date of last PAP: \_\_\_\_\_ Any abnormal PAPs in past? \_\_\_\_\_

Breast lumps (Do you examine yourself for breast lumps? Yes / No)  Nipple discharge  Breast tenderness

How would you rate your sexual energy?  Low  Medium  High

How would you rate your overall level of sexual satisfaction?  Low  Medium  High

Do you douche regularly? Yes / No If yes, with what? \_\_\_\_\_

Do you use vaginal lubricants? Yes / No If yes what kind (s)? \_\_\_\_\_

**FEMALE FERTILITY HISTORY**

Name of gynecologist &/or reproductive endocrinologist: \_\_\_\_\_

Do you practice birth control? Yes / No What type and for how long (i.e., birth control pill, IUD, condoms, etc.)? \_\_\_\_\_

Have you kept a Basal Body Temperature Chart? Yes / No (If yes, please bring copies to your initial visit.)

Have you ever been treated for infertility? Yes / No If yes, when, with whom, what was tried? \_\_\_\_\_

Have you taken medications to stimulate ovulation? Yes / No Please describe type, duration, & time frame: \_\_\_\_\_

Have your fallopian tubes been medically evaluated? Yes / No What were the results? \_\_\_\_\_

Have you had any gynecological operations or procedures (i.e., laparoscopy, abdominal surgery, pelvic / abdominal imagery such as ultrasound, etc.)? Yes / No If yes, please explain \_\_\_\_\_

Have you had blood work done to assess fertility & hormone factors? Yes / No If yes, please explain or bring labs: \_\_\_\_\_

If you have been trying to conceive, how long have you been actively trying? \_\_\_\_\_

Have you been given a medical diagnosis related to infertility or woman's reproductive health? Yes / No

If yes, please explain \_\_\_\_\_

Are you aware of any exposure to drugs or chemicals while your mother was pregnant with you? Yes / No

If yes, please describe \_\_\_\_\_

Any additional history or relevant information: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEN'S GENITOURINARY HEALTH HISTORY**

Family Medical History of Prostate Disease, Cancer, Hypertrophy, explain \_\_\_\_\_

**Have you experienced any of the following?**

- Prostate Hypertrophy                       Failure to Ejaculate                       Premature Ejaculation
- Failure to maintain erection               Inability to have erection               Low Libido
- Dribbling Urination                       Weak Urine Stream                       Pressure or fullness in prostate area
- Abnormal Penile discharge: Color: \_\_\_\_\_ Consistency: \_\_\_\_\_ Odor: \_\_\_\_\_
- History of Kidney Infections, dates \_\_\_\_\_  History of Urinary Bladder Infections, dates \_\_\_\_\_
- History of trauma to the genital region, explain \_\_\_\_\_  Genital Sores
- Sexually transmitted diseases: \_\_\_\_\_
- Breast lumps (do you examine yourself for breast lumps? Yes/ No)  Nipple discharge

How would you rate your sexual energy?  Low               Medium               High  
 How would you rate your overall level of sexual satisfaction?  Low  Medium               High  
 Have you experienced erectile dysfunction? Yes / No  
 Have you used medication (s) for erection? Yes / No. If yes, what type & time frame? \_\_\_\_\_

**MEN'S FERTILITY HISTORY**

Do you practice birth control? Yes / No What type and for how long (i.e., condoms, vasectomy, etc.)? \_\_\_\_\_

# of Pregnancies with partner (s) & dates: \_\_\_\_\_

# of Children / Birthdates: \_\_\_\_\_

Have you been given a medical diagnosis related to infertility? Yes / No. If yes explain. \_\_\_\_\_

Have you ever been treated for infertility? \_\_\_\_\_ If yes, when, with whom, what was tried? \_\_\_\_\_

Have you had a semen analysis? Yes / No. If yes, please explain or bring labs: \_\_\_\_\_

If you have been trying to conceive, how long have you been actively trying? \_\_\_\_\_

Do you wear tight fitting clothing that would confine genital region? Yes / No

Do you ride bikes long distance or mountain bike? Yes / No

Have you been exposed to any know environmental toxins or hormones? Yes / No If yes what? \_\_\_\_\_

Are you aware of any exposure to drugs or chemicals while your mother was pregnant with you? Yes / No.

If yes please describe \_\_\_\_\_

Are you presently taking steroids for any reason? Yes / No. If yes, what are taking and why? \_\_\_\_\_

Any additional history or relevant information: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please check below: *Excessive, Moderate, Minimal, or None*. Please add comments.

	Excessive	Moderate	Minimal	None	
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coffee / Tea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appetite:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Energy Level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vitamins:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food Intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Salt Intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sugar Intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are you willing to actively participate in your treatment and possibly modifying aspects of your diet and lifestyle that may be contributing to or aggravating your symptoms or condition? \_\_\_\_\_  
\_\_\_\_\_

Is there anything I have forgotten to ask which is important for me to know? \_\_\_\_\_  
\_\_\_\_\_

Do you have any questions for me? \_\_\_\_\_  
\_\_\_\_\_