Comprehensive History Questionnaire

Patient Name: ___________________________ Date: __________________

Occupation ____________________________
Reason for visit: _________________________

List Current Health Problems for which you are being treated: __________________________

What types of therapies have you tried for these problem(s) or to improve you health over-all:  
______diet ______fasting ______vitamins/minerals/herbs ______chiropractic  
______acupuncture ______conventional drugs ______homeopathy ______other

Do you experience any of these symptoms EVERY DAY? Circle all that apply.

Debilitating fatigue  Panic Attacks  Vomiting  Chronic  
Depression  Headaches  Diarrhea  pain/inflammation  
Disinterested in sex  Dizziness  Constipation  Bleeding  
Disinterested in eating  Insomnia  Fecal incontinence  Discharge  
Shortness of Breath  Nausea  Low Grade fever  itching/rash

Current Medication(prescription or over-the-counter) ____________________________

Major Hospitalizations, Surgeries, injuries: List the date and WHY.

List all other physicians that you see and why: _____________________________

Do you have any allergies to medication? ______ If yes please list: ____________________________

Do you have food allergies? ______ If yes please list: ____________________________

Level of stress you are experiencing on a scale of 1 to 10(1 being the lowest)_____
Have you consider yourself underweight, overweight, just right? ______
Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? ______
Is your job associated with potentially harmful chemicals or health +/or life threatening activities? ______
What are your current health goals? ____________________________
Medical History
- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colon
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other ______________________________

Medical (Women)
- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other ______________________________

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Age of first period ______
Date of last gynecological exam ______
Mammogram □ + □ - पप □ + □ -
Form of birth control ____________
# of children ____________
# of pregnancies ____________
Cesarean ____________
Surgical menopause ____________
Menopause ____________
Length of last menstrual cycle ______
Interval of time between cycles ______
Any recent changes in normal menstrual flow (e.g., heavy, large clots, scanty) ______

Family Health History (Parents and Siblings)
- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other ______________________________

Health Habits
- Tobacco:
  - Cigarettes: #/day ________
  - Cigars: #/day ________
- Alcohol:
  - Wine: # of glasses/d or wk ________
  - Liquor: # of drinks/d or wk ________
  - Beer: # of glasses/d or wk ________
- Coffee:
  - Tea: # of cups/d or wk ________
  - Soda w/coffee: # of cups/d ________
- Other sources ____________________________

Exercises
- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30.45 minutes duration per workout
- More than 30 minutes
- Walk
  - Run, jog, jump rope
  - Weight lift
  - Swim
  - Box
  - Yoga
  - Other ______________________________

Nutrition & Diet
- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
  - dairy
  - wheat
  - eggs
  - soy
  - corn
  - all gluten
- Other ______________________________

Food Frequency
- Servings per day:
  - Fruits (citrus, melons, etc.) ________
  - Dark green or deep yellow/orange vegetables ________
  - Grains (unprocessed) ________
  - Beans, peas, legumes ________
  - Dairy, eggs ________
  - Meat, poultry, fish ________

Eating Habits
- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat consistently whether hungry or not
- Generally eat on the run
- Add salt to food

Current Supplements
- Multivitamin/mineral
- Vitamin C
- Vitamin D
- EPA/DHA
- Evening Primrose/GPU
- Calcium, source ________
- Magnesium
- Zinc
- Minerals, describe ________
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytoneutraceutical blends)
- Liquid meals
- Other ______________________________

Would you like to:
- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependant on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flu
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)
- Other ______________________________

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