Great Health Holistic

Adult Health History Questionnaire

Name: _____ Age: ___ DOB _____ Today's Date: _____

Gender: ___Male ___Female ___Prefer not to answer

Address: _____

No. and Street City/Town State Zip Code

Work Phone: (____)_____-_____ Home Phone: (____)____-_____)

Cell Phone: (____)____-_____ Email Address: _____

Reason for appointment: _____

How long have you had this concern? _____. Please check if this concern:

___Is getting worse ___Is constant ___Is worse in the morning ___Is worse in the evening.

Please list additional current health conditions you are experiencing:

Date of last physical exam? _____ Any Abnormal findings? ___yes ___no

Please explain if yes:

_____

_____

_____

Medication Allergy and/or Intolerance: please list any medication or supplement you are allergic to or which caused unpleasant side effects. Include the name of the substance, the reaction and any treatment given. Use additional sheets if necessary:

Medication/Supplement Date Reaction Any treatment Given

_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____

Medications:
List medicines (prescription and over the counter), that you are currently taking or have taken recently. Use additional sheet if necessary:

Medication Dose Frequency Started Stopped

_____ _____ _____ _____ _____

Medications Continued:

Medication Dose Frequency Started Stopped

_____ _____ _____ _____ _____

_____

_____

_____

Vitamins, Minerals and other nutritional supplements:
Please list your nutritional supplements, including vitamins, minerals, herbs, homeopathic remedies. Please list dosage (MG, IU, etc.) Use additional sheet if necessary.

Vitamin/Herb/Supplement Dose Frequency Started Stopped

_____ _____ _____ _____ _____

_____

Family History: Family background may be related to medical conditions. Please fill in all of the following to the best of your ability:

Relationship Living? Age Deceased? Cause of Death Illnesses

_____

_____

_____

_____
_____
_____

Personal History: Height_____ **Weight**_____
Occupation_____

Tobacco Use: Please list the types of tobacco products you have or currently use, the amount used (i.e. # of packs per day), age you started age you stopped. If none, please state “none”.

Type of Tobacco	Amount/Packs per day	Age started	Age stopped

Alcohol Use: Please list what types of alcoholic beverages you drink, amount per week. If none, please state “none”.

Type of Alcohol	Amount per day/week/month	Age started	Age stopped

Physical Exercise: Please state forms of exercise, if any, you participate in. If none, please state “none”.

Type of Exercise	How long each time	Times per week

Do you sleep well? ___Yes ___No Wake feeling rested? ___Yes ___No
How many hours per night do you sleep?_____

PLEASE CHECK OFF IF YOU HAVE HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS:

VASCULAR
__ANEMIA
__BLOOD CLOTS
__COLD HANDS/FEET
__DEEP LEG PAIN
__EASY BLEEDING/BRUISING
__THROMBOPHLEBTIS
__VARICOSE VEINS
__STROKE, TYPE _____
__ALZEIMER'S/DEMENTIA

CARDIOVASCULAR
__ANGINA
__CHEST PAIN/TIGHTNESS
__FAITNING
__FLUID RETENTION
__SWELLING IN ANKLES
__HEART ATTACK, DATE _____
__HIGH BLOOD PRESSURE
__LOW BLOOD PRESSURE
__HIGH CHOLESTEROL
__HEART MURMUR
__PACEMAKER, DATE _____
__PALPITATIONS/FLUTTERING
__PHEUMATIC FEVER

ENDOCRINE
__FATIGUE EATING RELIEVES
__FATIGUE SLEEP RELIEVES
__HEAT/COLD INTOLERANCE
__EXCESSIVE THIRST
__SHAKY IF HUNGRY
__LIGHTHEADED IF MISS A MEAL
__CRAVE SWEETS
__HYPOGLYCEMIA
__DIABETES TYPE 1 or 2
__HYPERTHYROID
__HYPOTHYRIOD
__SEASONAL DEPRESSION

EARS
__DIZZINESS
__EARACHE/INFECTION
__CHRONIC INFECTIONS
__HEARING LOSS
__TINNITUS/RINGING
__EXCESSIVE WAX

VISION/EYES
__BLURRINESS
__CATARACTS
__DOUBLE VISION
__DIMINISHED NIGHT VISION
__EYE PAIN
__GLAUCOMA
__MACULAR DEGENERATION
__RETINAL DETACHMENT
__SPOTS/FLOATERS IN EYE
__LASER EYE SURGERY
__GLASSES/CONTACTS

GASTROINTESTINAL
__BOWEL MOVEMENTS, HOW OFTEN?
_____PER DAY/_____PER WEEK
__ABDOMINAL PAIN
__BLOOD IN STOOL
__CONSTIPATION
__DIARRHEA
__IBS
__FREQUENT BELCHING
__FREQUENT GAS/BLOATING
__DIVERTICULOSIS
__GALL BLADDER PROBLEMS
__HIATAL HERNIA
__HEARTBURN/ACID REFLUX
__BARRETT'S DISEASE
__SPASTIC COLON
__HEMORRHIODS
__TROUBLE SWALLOWING
__LIVER DISEASE
__HEPATITUS, TYPE _____
__JAUNDICE
__FREQUENT NAUSEA/VOMITING
__VOMITING BLOOD
__PARASITES, DIAGNOSED _____

HEAD
__FREQUENT HEADACHES
__MIGRAINES, HOW OFTEN_____
__HEAD INJURY/CONCUSSION, DATE:_____
__JAW/TMJ PROBLEMS

NECK
__GOITER
__PAIN/STIFFNESS
__SWOLLEN GLADNS
__WHIPLASH HISTORY

NEUROLOGICAL

__EPILEPSY
__SEIZURES
__BRAIN INJURY
__TREMOR
__NUMBNESS/TINGLING
__PARALYSIS
__TOURETTE'S SYNDROME
__NEUROMA
__FREQUENT FAINTING
__INSOMNIA

NOSE/SINUS/LUNGS

__SEASONAL ALLERGIES
__FREQUENT RUNNY NOSE
__SINUS INFECTION
__CHRONIC CONGESTION
__EXCESSIVE SNORING
__SLEEP APNEA
__RESPIRATORY DISEASE, TYPE _____
__ASTHMA WET/DRY
__BRONCHITIS
__CHRONIC COUGH
__DIFFICULTY/PAIN BREATHING
__EMPHYSEMA
__PHEUMONIA
__SHORTNESS OF BREATH
__COUGHING UP BLOOD
__SPUTUM
__TUBERCULOSIS
__RIB FRACTURE

MOUTH/THROAT

__FREQUENT SORE THROAT
__SORE TONGUE/LIPS
__COATING ON TONGUE
__METALLIC TASTE IN MOUTH
__CHRONIC HOARSENESS
__UNUSUALLY BAD BREATH
__DRY MOUTH
__MOUTH BREATHING
__TEETH GRINDING/CLENCHING
__DENTAL PROBLEMS

SKIN

__CHRONIC ACNE
__CYSTIC ACNE
__HORMONAL ACNE
__CHRONIC RASHES
__CHRONIC ITCHING
__ECZMEA
__PSORIASIS
__FREQUENT HIVES
__SHINGLES
__EXCESSIVE DRYNESS

MUSCULOSKELETAL

__ARTHRITIS
__JOINT PAIN/STIFFNESS
__JOINT INJURY
__JOINT REPLACEMENT
__FALLEN ARCHES
__GOUT
__CARPAL TUNNEL SYNDROME
__RESTLESS LEG SYNDROME
__SCIATICA
__TENDONITIS
__OSTEOPENIA
__OSTEOPOROSIS
__BROKEN BONES
__NECK PAIN
__UPPER BACK PAIN
__LOWER BACK PAIN
__MUSCLE CRAMPS/SPASMS
__MUSCLE WEAKNESS
__MUSCLE ATROPHY

IMMUNE

__FREQUENT COLDS
__CHRONIC SWOLLEN GLANDS
__CHRONIC INFECTIONS
__SLOW WOUND HEALING
__STD/STI:_____
__AUTOIMMUNE DISORDER:
    __CROHN'S DISEASE
    __FIBROMYALGIA
    __HASHIMOTO'S THYROIDITIS
    __LUPUS
    __MULTIPLE SCLEROSIS
    __RHEUMATOID ARTHRITIS
    __SCLERODERMA
    __OTHER:_____
__CANCER: TYPE/DATE DIAGNOSED:
_____
_____

MENTAL HEALTH/EMOTIONAL

__ANXIETY/NERVOUSNESS
__MOOD SWINGS
__FREQUENT TENSION
__DIFFICULTY CONCENTRATING
__DECREASED MEMORY
__EATING DISORDER:
TYPE/AGE BEGAN/ENDED
_____
__MENTAL ILLNESS:
TYPE/AGE DIAGNOSED
_____

URINARY

__BLADDER INFECTION
__BLADDER STONES
__FREQUENT UTI
__KIDNEY STONES
__KIDNEY PAIN
__BLOOD IN URINE
__BURNING/PAINFUL URINATION
__DIFFICULT URINATION
__FREQUENT/URGENT URINATION
__WEAK STREAM WITH URINATION
__LOSS OF BLADDER CONTROL
__BED WETTING

REPRODUCTIVE MALE

__HERNIA
__FERTILITY ISSUES
__PROSTATE PROBLEMS
__PENILE DISCHARGE
__TESTICULAR PAIN
__ERECTILE DYSFUNCTION
__LOW SEX DRIVE
__ERECTION CONCERNS
__IMPOTENCE

REPRODUCTIVE FEMALE

__AGE WHEN MENSES BEGAN
__LENGTH OF CYCLE _____
ARE YOUR CYCLES REGULAR? YES/NO
IF MENOPAUSAL, AGE OF LAST MENSES?
_____
OF PREGNANCIES _____
OF MISCARRIAGES _____
__ABNORMAL PAP SMEAR
__BIRTH CONTROL
TYPE: _____
__HORMONE REPLACEMENT
__PAINFUL PERIODS
__EXCESSIVE/HEAVY BLEEDING
__CLOTTING WITH PERIOD
__OVARIAN CYSTS
__UTERINE FIBROIDS
__POLYCYSTIC OVARIAN SYNDROME
__ENDOMETRIOSIS
__HYSTERECTOMY
__REMOVAL OF OVARIES
__BREAST LUMPS/CYSTS
__HOT FLASHES
__DECREASED SEX DRIVE
__PAINFUL INTERCOURSE
__VAGINAL DRYNESS
__EXCESSIVE/UNUSUAL DISCHARGE
__VAGINAL YEAST INFECTION
__FERTILITY ISSUES

OTHER HEALTH CONCERNS

_____
_____
_____