Great Health Holistic

Adult Health History Questionnaire

Name:	Age:	_ DOB		_ Today's Date:
Gender:MaleFemale Address:	Prefer no	t to answer		
No. and Street City/ Work Phone: (· · · · · · · · · · · · · · · · · · ·
Cell Phone: ()En	nail Addre	ess:		
Reason for appointment:				
How long have you had this concern concern:Is getting worseIs constant evening.	ls w	orse in the	morning	JIs worse in the
Please list additional current health o	onditions	you are ex	perienci	ng:
Date of last physical exam? Please explain if yes:		Any Abno	ormal fin	dings?yesnc
Medication Allergy and/or Intolera are allergic to or which caused unple substance, the reaction and any trea	asant sid	e effects. Ir	nclude th	ne name of the
Medication/Supplement Date Given	Rea	action		Any treatment

se d:	if necessary: Frequency	Started	<u>Stopped</u>
d:			
se	<u>Frequency</u>	<u>Started</u>	Stopped_
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ent De	ose Frequ	ency Sta	rted
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	l other nutr al suppleme Please list c	l other nutritional supplements al supplements, including vitamir Please list dosage (MG, IU, etc.)	l other nutritional supplements: al supplements, including vitamins, minerals, he Please list dosage (MG, IU, etc.) Use additional

Personal History: He Occupation	ght Weight	
	st the types of tobacco products you have or currently use acks per day), age you started age you stopped. If none, p	
Type of Tobacco	Amount/Packs per day Age started Age stopped	•
Alcohol Use: Please li	 t what types of alcoholic beverages you drink, amount per	r
week. If none, please s	31	r
week. If none, please s Type of Alcohol stopped	ate "none". Amount per day/week/month Age started Age	
week. If none, please s Type of Alcohol stopped Physical Exercise: Please state "none".	ate "none".	

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

<u>VASCULAR</u>	<u>VISION/EYES</u>
ANEMIA	BLURRINESS
BLOOD CLOTS	CATARACTS
COLD HANDS/FEET	DOUBLE VISION
DEEP LEG PAIN	DIMINISHED NIGHT VISION
EASY BLEEDING/BRUISING	EYE PAIN
THROMBOPHLEBTIS	GLAUCOMA
VARICOSE VEINS	MACULAR DEGENERATION
STROKE, TYPE	RETINAL DETACHMENT
ALZEIMER'S/DEMENTIA	SPOTS/FLOATERS IN EYE
	LASER EYE SURGERY
<u>CARDIOVASCULAR</u>	GLASSES/CONTACTS
ANGINA	
CHEST PAIN/TIGHTNESS	<u>GASTROINTESTINAL</u>
FAITNING	BOWEL MOVEMENTS, HOW OFTEN?
FLUID RETENTION	PER DAY/PER WEEK
SWELLING IN ANKLES	ABDOMINAL PAIN
HEART ATTACK, DATE	BLOOD IN STOOL
HIGH BLOOD PRESSURE	CONSTIPATION
LOW BLOOD PRESSURE	DIARRHEA
HIGH CHOLESTEROL	IBS
HEART MURMUR	FREQUENT BELCHING
PACEMAKER, DATE	FREQUENT GAS/BLOATING
PALPITATIONS/FLUTTERING	DIVERTICULOSIS
PHEUMATIC FEVER	GALL BLADDER PROBLEMS
	HIATAL HERNIA
<u>ENDOCRINE</u>	HEARTBURN/ACID REFLUX
FATIGUE EATING RELIEVES	BARRETT'S DISEASE
FATIGUE SLEEP RELIEVES	SPASTIC COLON
HEAT/COLD INTOLERANCE	HEMORRHIODS
EXCESSIVE THIRST	TROUBLE SWALLOWING
SHAKY IF HUNGRY	LIVER DISEASE
LIGHTHEADED IF MISS A MEAL	HEPATITUS, TYPE
CRAVE SWEETS	JAUNDICE
HYPOGLYCEMIA	FREQUENT NAUSEA/VOMITING
DIABETES TYPE 1 or 2	VOMITING BLOOD
HYPERTHYROID	PARASITES, DIAGNOSED
HYPOTHYRIOD	
SEASONAL DEPRESSION	<u>HEAD</u>
	FREQUENT HEADACHES
<u>EARS</u>	MIGRAINES, HOW OFTEN
DIZZINESS	HEAD INJURY/CONCUSSION,
EARACHE/INFECTION	DATE:
CHRONIC INFECTIONS	JAW/TMJ PROBLEMS
HEARING LOSS	
TINNITUS/RINGING	<u>NECK</u>
EXCESSIVE WAX	GOITER
	PAIN/STIFFNESS
	_SWOLLEN GLADNS
	WHIPLASH HISTORY

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RESPIRATORY DISEASE, TYPE	EXCESSIVE SNORING	FALLEN ARCHES
RESPIRATORY DISEASE, TYPE	SLEEP APNEA	GOUT
RESTLESS LEG SYNDROME 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 RESTLESS LEG SYNDROME SCIATICA TENDONITIS OSTEOPENIA OSTEOPENIA OSTEOPENIA OSTEOPENIA OSTEOPENIA DEVELOPENIA OSTEOPENIA OSTEOPENIA DEVELOPENIA UPPER BACK PAIN MUSCLE CRAMPS/SPASMS MUSCLE WEAKNESS MUSCLE ATROPHY IMMUNE FREQUENT COLDS CHRONIC SWOLLEN GLANDS CHRONIC INFECTIONS SLOW WOUND HEALING STD/STI: AUTOIMMUNE DISORDER: FIBROMYALGIA HASHIMOTO'S THYROIDITIS LUPUS MULTIPLE SCLEROSIS RHEUMATOID ARTHRITIS SCLERODERMA OTHER:	RESPIRATORY DISEASE.	CARPAL TUNNEL SYNDROME
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METALLIC TASTE IN MOUTH CHRONIC HOARSENESS UNUSUALLY BAD BREATH DRY MOUTH MOUTH MOUTH BREATHING TEETH GRINDING/CLENCHING DENTAL PROBLEMS MULTIPLE SCLEROSIS RHEUMATOID ARTHRITIS SCLERODERMA OTHER:	SORE TONGUE/LIPS	CHRONIC SWOLLEN GLANDS
CHRONIC HOARSENESS UNUSUALLY BAD BREATH DRY MOUTH MOUTH BREATHING TEETH GRINDING/CLENCHING DENTAL PROBLEMS LUPUS MULTIPLE SCLEROSIS RHEUMATOID ARTHRITIS SCLERODERMA OTHER:	COATING ON TONGUE	CHRONIC INFECTIONS
UNUSUALLY BAD BREATH DRY MOUTH MOUTH CROHN'S DISEASE MOUTH BREATHING TEETH GRINDING/CLENCHING DENTAL PROBLEMS LUPUS MULTIPLE SCLEROSIS RHEUMATOID ARTHRITIS SCLERODERMA OTHER:	METALLIC TASTE IN MOUTH	SLOW WOUND HEALING
DRY MOUTH MOUTH BREATHING TEETH GRINDING/CLENCHING DENTAL PROBLEMS LUPUS MULTIPLE SCLEROSIS RHEUMATOID ARTHRITIS SCLERODERMA OTHER:	CHRONIC HOARSENESS	STD/STI:
DRY MOUTH MOUTH BREATHING TEETH GRINDING/CLENCHING DENTAL PROBLEMS LUPUS MULTIPLE SCLEROSIS RHEUMATOID ARTHRITIS SCLERODERMA OTHER:	UNUSUALLY BAD BREATH	AUTOIMMUNE DISORDER:
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TEETH GRINDING/CLENCHING DENTAL PROBLEMS LUPUS MULTIPLE SCLEROSIS RHEUMATOID ARTHRITIS SCLERODERMA OTHER:	MOUTH BREATHING	
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MULTIPLE SCLEROSIS RHEUMATOID ARTHRITIS SCLERODERMA OTHER:		
RHEUMATOID ARTHRITIS SCLERODERMA OTHER:	DENTALT ROBLEMO	
SCLERODERMA OTHER:		
OTHER:		
CANCER. ITPE/DATE DIAGNOSED:		
		CANCER. ITFLIDATE DIAGNOSED.

MENTAL HEALTH/EMOTIONAL	REPRODUCTIVE FEMALE
ANXIETY/NERVOUSNESS	AGE WHEN MENSES BEGAN
MOOD SWINGS	LENGTH OF CYCLE
FREQUENT TENSION	ARE YOUR CYCLES REGULAR? YES/NO
DIFFICULTY CONCENTRATING	IF MENOPAUSAL, AGE OF LAST MENSES?
DECREASED MEMORY	
EATING DISORDER:	# OF PREGNANCIES
TYPE/AGE BEGAN/ENDED	# OF MISCARRIAGES
	ABNORMAL PAP SMEAR
MENTAL ILLNESS:	BIRTH CONTROL
TYPE/AGE DIAGNOSED	TYPE:
	HORMONE REPLACEMENT
	PAINFUL PERIODS
<u>URINARY</u>	EXCESSIVE/HEAVY BLEEDING
BLADDER INFECTION	CLOTTING WITH PERIOD
BLADDER STONES	OVARIAN CYSTS
FREQUENT UTI	UTERINE FIBROIDS
KIDNEY STONES	POLYCYSTIC OVARIAN SYNDROME
KIDNEY PAIN	ENDOMETRIOSIS
BLOOD IN URINE	HYSTERECTOMY
BURNING/PAINFUL URINATION	REMOVAL OF OVARIES
DIFFICULT URINATION	BREAST LUMPS/CYSTS
FREQUENT/URGENT URINATION	HOT FLASHES
WEAK STREAM WITH URINATION	DECREASED SEX DRIVE
_LOSS OF BLADDER CONTROL	PAINFUL INTERCOURSE
BED WETTING	VAGINAL DRYNESS
	EXCESSIVE/UNUSUAL DISCHARGE
REPRODUCTIVE MALE	VAGINAL YEAST INFECTION
HERNIA	FERTILITY ISSUES
FERTILITY ISSUES	
PROSTATE PROBLEMS	OTHER HEALTH CONCERNS
PENILE DISCHARGE	
TESTICULAR PAIN	
ERECTILE DYSFUNCTION	
LOW SEX DRIVE	

__ERECTION CONCERNS

__IMPOTENCE