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New Patient
Adult Health History Questionnaire

The purpose of this questionnaire is to have you gather key information about your past and current level of health. I hope that in the process of completing this questionnaire that additional questions or insights will arise.

Please devote some focused time and attention to thoughtfully complete this form. **It is essential that you complete this questionnaire before your first office visit.** Please do not mail your completed orientation materials since the USPS is unreliable concerning timely deliveries. You can choose to drop off the paperwork in advance and place the materials in the drop box outside the door of my office or simply bring the completed materials with you to your first office visit.
I do not work with email-based medicine and do not have an online portal for that category of communication. I do not utilize text-based medicine.

Please read and answer each question carefully. If there is a question you have difficulty answering, circle that question and we can discuss it in person.

Your answers to these questions are confidential. All of our conversations and your medical records are also confidential. I do not record office visits, and I do not use AI generated charting.

I know that this questionnaire is long and involved, but it is helpful to me to have this baseline of medical and personal data in order to better understand how I can best help your unique medical situation.

I look forward to working with you in your pursuit of health,

Steve Paulus, DO, MS

Name of Patient: _____

❑ I have completed my own questionnaire.

If the patient is unable to complete this form, please provide the following information:

History written/recorded by: _____

Relationship to patient: _____

WHAT ARE YOUR HEALTH CONCERNS?
What is/are the primary problem(s) you would like help with?

When did this problem begin? *Please be specific:*

Why do you think this problem occurred? *What are your theories?*

Are you concerned that this problem could be something serious? ❑ Yes ❑ No
If yes, please explain:

How does this problem interfere with your daily activities? *(e.g. work, sleep, play, sex, or exercise)*

What kind of self-care treatments have been helpful? *(e.g. ice, heat, hot bath, home TENS unit, stretching, rest, etc.)*

Have you seen any other health care practitioner for this problem? ❑ Yes ❑ No

Please list the physicians (primary care, specialists, surgeons), nurse practitioners, physical therapists, naturopaths, acupuncturists, chiropractors, Rolfers, massage therapists, etc. that you have seen to try to help this problem:

Have you been given a diagnosis for this problem? ❑ Yes ❑ No *If yes, what is the diagnosis?*

Has there ever been an event, trauma, surgery, or other incident (emotional or physical) that has significantly changed your life?

I describe my health as: *(circle one of the following):*

EXCELLENT **GOOD** **POOR**

VERY GOOD **FAIR** **I'M NOT SURE**

X-RAYS/IMAGING HISTORY

Have you had any of the following tests, x-rays, or imaging studies? *If you have, try to list the year of imaging.*

TEST	**YEAR of IMAGING**		
CAT/CT Scan	_____	of what part of your body?	_____
MRI Scan	_____	of what part of your body?	_____
Back or Hip X-Rays	_____		
Neck X-Rays	_____		
Extremity X-Rays	_____	of what part of your body?	_____
Ultrasound Exam	_____	of what part of your body?	_____
Bone Scan	_____		
Bone Density Test for Osteoporosis	_____		

Other Important Imaging Tests:

HEALTH AND DISEASE HISTORY OVERVIEW:

Eyes ❑ No Specific Problems
❑ *I have or had a problem in this area. Please describe:*

Ears, Nose, Sinuses, Mouth, Throat, and Dental ❑ No Specific Problems
❑ *I have or had a problem in this area. Please describe:*

Heart, Circulation, Arteries, and Veins ❑ No Specific Problems
❑ *I have or had a problem in this area. Please describe:*

Lungs and Breathing ❑ No Specific Problems
❑ *I have or had a problem in this area. Please describe:*

Digestion, Esophagus, Stomach, and Intestines ❑ No Specific Problems
❑ *I have or had a problem in this area. Please describe:*

Kidney and Bladder ❑ No Specific Problems
❑ *I have or had a problem in this area. Please describe:*

Skin and Hair ❑ No Specific Problems
❑ *I have or had a problem in this area. Please describe:*

Mental Health, Mood, and Emotions ❑ No Specific Problems
❑ *I have or had a problem in this area. Please describe:*

Hormones and Diabetes ❑ No Specific Problems
❑ *I have or had a problem in this area. Please describe:*

Blood and Lymph ❑ No Specific Problems
❑ *I have or had a problem in this area. Please describe:*

For Women: Do you have any other women's health concerns? ❑ No Specific Problems
❑ *I have or had a problem in this area. Please describe:*

For Men: Do you have any other men's health concerns? ❑ No Specific Problems
❑ *I have or had a problem in this area. Please describe:*

PAST SURGICAL HISTORY/OPERATIONS

❑ *I have never had surgery. I have all my "original equipment."*

Have you had any of the following surgeries? Please mark "X" for yes, and then fill in the year.

	Surgery	Year		Surgery	Year
_____	Tonsillectomy	_____	_____	Sinus Surgery or Drainage	_____
_____	Hernia repair	_____	_____	Wisdom Teeth Removed	_____
_____	Varicose Vein Stripping	_____	_____	Appendectomy	_____
_____	Hemorrhoid Surgery	_____	_____	Gall Bladder Surgery	_____
_____	Hip Surgery	_____	_____	Knee Surgery – Arthroscopic	_____
_____	Cosmetic Surgery	_____	*Please describe the type of cosmetic surgery:*		
_____	Cancer Surgery	_____	*Please describe what type of cancer surgery you had:*		

MEN:

_____	Vasectomy	_____
_____	Prostate Surgery	_____

WOMEN:

_____	C-Section	_____
_____	Tubal Ligation	_____
_____	Hysterectomy	_____

Have you had any other surgeries not mentioned above? *If you have, please list them:*

PAST MEDICAL HISTORY/ILLNESSES

Have you ever had any of the following specific medical problems? Please mark "X" for yes.

_____	GERD/ Reflux Esophagitis/Gastritis	_____	Thyroid Disease (Hypothyroid or Hyperthyroid)
_____	IBS/ Irritable Bowel	_____	Osteoporosis
_____	TMJ-Chronic Jaw Pain	_____	Fibromyalgia
_____	Chronic Yeast/Fungal Infection	_____	Chronic Fatigue Syndrome
_____	Lyme Disease	_____	Cancer—what kind?

Please give additional details or describe other important medical problems:

Do you have environmental, seasonal, and perennial allergies, such as allergies to pollen (hay fever, grasses, trees, etc.), mold, animals, dust mites, foods, chemicals, etc?

Please list:

Have you ever had ANY form of INJECTION THERAPY (epidural injection, SI joint injection, prolotherapy, trigger point injections, stem cell injections, platelet injections-PRP)? ❑ Yes ❑ No *If yes, please give the details*

INJURY HISTORY

Have you ever had any fractures/broken bones? ❑ Yes ❑ No
Have any fractures been set or fixed surgically? ❑ Yes ❑ No
Please list the bone(s) broken and the date:

Have you ever had a head injury, concussion, or other forceful blow to your head? ❑ Yes ❑ No
If yes, please give the details of the incident and the dates:

Have you had any other significant accidents or falls? ❑ Yes ❑ No
If yes, please give the details of the incident and the dates:

DENTAL HISTORY

Have you ever worn braces? ❑ Yes ❑ No If yes, how old were you? _____
Do you currently use a mouth guard, retainer, or dental appliance for any reason? ❑ Yes ❑ No
If yes, please give more specific details:

Have you ever had <u>any</u> teeth pulled? ❑ Yes ❑ No *If yes, which teeth and when?*

Do you have problems with your jaw (TMJ or Temporal Mandibular Joint)? ❑ Yes ❑ No
If yes, please give more details:

Do you suffer from bruxism (teeth clenching or grinding)? ❑ Yes ❑ No
If yes, please give more details:

OTHER HISTORY:

Do you currently use a heel lift? ❑ Yes ❑ No

Do you currently use a shoe orthotic/insert? ❑ Yes ❑ No

Are you currently receiving **Botox injections** for any reason: headaches, migraines, cosmetic reasons, neck pain, tremor, excessive sweating, etc.? ❑ Yes ❑ No

❑ I am right-handed. **❑ I am left-handed**

COVID VACCINE HISTORY:

❑ I chose not to receive the Covid vaccines.

Did you receive the initial two-part Covid vaccine? ❑ Yes ❑ No

Did you receive ANY Covid vaccine boosters? ❑ Yes ❑ No

At any point in the past several years have you been diagnosed with Covid-19 verified by laboratory testing? ❑ Yes ❑ No

If yes, how many times have you had Covid-19?

Do you currently have **Long Covid** or have you previously been diagnosed with **Long Covid**? ❑ Yes ❑ No

VITAMIN & NUTRITIONAL SUPPLEMENT & HERB HISTORY

Please list all supplements, vitamins, minerals, herbs, or remedies that you take on a *daily or regular* basis:

Are you currently taking a constitutional Homeopathic remedy? ❑ Yes ❑ No
If yes, which remedy(s)? If yes, who is your Homeopath?

MEDICATION HISTORY

Please list ALL prescription medications that have been prescribed by a physician that you take on a *daily or regular* basis.

Please list ALL prescription medications that have been prescribed by a physician that you take on an *as needed* basis.

Have you taken any of the following Over-the-Counter (OTC) Medications in the past month *for any reason*? (mark with an X for yes)

___ Ibuprofen/Advil/Motrin
___ Naproxen/Aleve
___ Aspirin

___ Tylenol/Acetaminophen
___ Excedrin
___ Bengay/Aspercream/TigerBalm
___ Lidocaine Patch

___ Prilosec/Omeprazole
___ Prevacid/Lansopraxole
___ Zegerid/Omeprazole+Sodium Bicarb

___ Pepcid/Famotidine
___ Tagamet/Cimetidine
___ Zantac/Rantitidine

___ Benadryl
___ Claritin/Zyrtec/Allegra
___ Decongestants/Sudafed
___ Decongestant Nose Spray
___ Flonase Nasal Spray

___ Tums/Rolaids
___ Liquid Antacids
___ Bicarbonate/Baking Soda
___ Pepto Bismol
___ Alka Seltzer

___ No Doz
___ Vivarin

___ Laxatives
___ Colace
___ Senakot
___ Castor Oil
___ Milk of Magnesia
___ Ducolax
___ Miralax
___ Citrucel
___ Metamucil
___ Benefiber
___ Enemas

___ Anti Fungus cream
___ Cortisone cream

Do you take any other OTC medications? ❑ Yes ❑ No *If yes, please list:*

Do you have any TRUE ALLERGIES to any medications? ❑ Yes ❑ No

If yes, please list the drugs and reaction:

Do you have any SENSITIVITIES (side effects other than allergies) to any medications?

❑ Yes ❑ No *If yes, please list the drugs and reactions:*

GENERAL HISTORY

How old are you? _____ How old do you feel? _____

My current height without shoes is: _____ feet _____ inches.

My current weight is: _____pounds.

To be at a health body weight, I'd need to:

Lose about_____ pounds.

Gain about_____ pounds.

❑ Maintain my current weight.

DIET HISTORY

Do you follow any special diet or a specific diet or nutritional program? *If yes, describe in detail:*

With respect to diet do you _____? Or, are you _____?

Eat Breakfast	❑ Yes	❑ No	Drink Sodas	❑ Yes	❑ No
Eat Lunch	❑ Yes	❑ No	Drink Diet Sodas	❑ Yes	❑ No
Eat Dinner	❑ Yes	❑ No	Drink Fruit Juices	❑ Yes	❑ No
Sometimes Skip Meals	❑ Yes	❑ No	Dairy Sensitive	❑ Yes	❑ No
Gluten Intolerance	❑ Yes	❑ No	Lactose Intolerant	❑ Yes	❑ No
Wheat Sensitive	❑ Yes	❑ No	Chew Gum Daily	❑ Yes	❑ No

How many times per week do you eat out at a restaurant? _____ times per week.

Are you sensitive or allergic to any foods? ❑ Yes ❑ No

If yes, which foods and how do you know that you are allergic to them?

SOCIAL HISTORY & HABITS

Relationship/Marital Status:

_____ Single
_____ Married
_____ Living with Significant Other/Partner
_____ Widow/er
_____ Divorced
_____ Divorced & Remarried

If you are in a relationship or married, how long have you been with your partner? _____

Do you have any children? ❑ Yes ❑ No If yes, how many and what ages? _____

Do you have any grandchildren? ❑ Yes ❑ No If yes, how many? _____

Education:

_____ years of High School _____ years of Technical School

_____ years of College _____ years Postgrad/Professional School

_____ years of Apprenticeship _____ Other (please describe) _____

Do you currently smoke cigarettes? ❑ Yes ❑ No **Do you vape?** ❑ Yes ❑ No

If yes, how many packs per day and for how many years total? ____ packs, for ____ years

Have you ever smoked cigarettes in the past? ❑ Yes ❑ No

If yes, when did you quit? ____ years ago

How many years did you smoke? For ____ years.

And how many packs per day did you smoke? ____ packs per day

Do you smoke, vape or ingest cannabis? ❑ Yes ❑ No

If yes, how frequently?

Do you drink alcohol? ❑ Yes ❑ No

If yes, how much daily = ____ glasses of wine/day ____ drinks/day ____ beers/day

If not daily, then how much monthly = ____ glasses of wine/mo. ____ drinks/mo. ____ beers/mo.

Do you use alcohol to help ease a painful condition? ❑ Yes ❑ No

Have you had any problems with alcohol in the past? ❑ Yes ❑ No

Do you use Psilocybin or mushrooms to help with pain or emotional issues? ❑ Yes ❑ No

Do you drink any caffeinated beverages? ❑ Yes ❑ No *If yes, how much of these:*

Coffee	_____ cups/day	Cola	_____ /day
Espresso Drinks	_____ shots/day	Energy Drinks	_____/day
Black Tea	_____ cups/day	Caffeinated Mints or Candy	_____/day

SLEEP HISTORY:

How many hours do you normally sleep? _____ hours

How many hours of sleep do you need to function optimally? _____ hours

What is your sleep position? *Check as many as apply.*

❑ on my back ❑ on my stomach ❑ on my right side ❑ on my left side
❑ I'm all over the place

Do you ever have trouble sleeping? ❑ Yes ❑ No

❑ I have problems falling asleep ❑ I wake up frequently in the night
❑ I wake up sometimes in the night, and have difficulty falling back to sleep

Do you ever use sleeping pills? ❑ Yes ❑ No ❑ Sometimes

Do you ever use alcohol to help you sleep? ❑ Yes ❑ No ❑ Sometimes

STRESS HISTORY:

How does stress effect you? *What happens to you physically and/or emotionally?*

Do you have methods of reducing the effects of stress on your body or emotions?

HOBBIES/RECREATIONAL ACTIVITIES, ETC.

Please list your hobbies, recreational activities, or ways you relax or have fun, such as gardening, cooking, woodworking, art, crafts, knitting, music, computer games, sports, games, collecting, scrapbooking, going to films, watching TV, fishing, being with friends, etc.?

EXERCISE HISTORY:

In an average week, I participate in some form of exercise:

_____ Almost every day

_____ At least ❑ 2 ❑ 3 ❑ 4 times a week.

_____ Maybe once a week.

_____ Hey, who has the time to exercise?

_____ **My medical condition prevents me from participating in regular exercise.**

The type of exercise(s) I engage in most often is (are) . . . (*Please "X" as many as apply)*

_____ I never exercise

_____ I exercise, but I don't like to sweat or get out of breath.

_____ Walking outdoors or hiking

_____ Walking on a treadmill

_____ Jogging or Running

_____ Elliptical Trainer or Stair Step Machine, etc.

_____ Swimming

_____ Aerobic dance or dance class like Zumba or Jazzercise

_____ Bicycling Outdoors

_____ Stationary Bike

_____ Rowing Machine

_____ Weight Lifting

_____ Pilates

_____ Yoga

_____ Tai Chi

_____ Crossfit

_____ Combat Fitness

_____ Exercise Classes

_____ Strength Training Classes

_____ Other Martial Arts – which one _____

_____ Dancing

_____ Other: _____

The primary reason(s) I exercise regularly is (are) to: *(please "X" as many as apply)*

_____ Improve my appearance

_____ Lose weight or maintain a health body weight

_____ Help control an existing health problem like high cholesterol, high blood pressure, diabetes, back pain, or other medical problem.

_____ Help prevent health problems

_____ Help relieve stress

_____ Feel better and have more energy

_____ I just enjoy physical exercise

OCCUPATIONAL HISTORY

Are you working now?

_____ Yes, I work in the home. ❑ Full time ❑ Part time

_____ Yes, I work outside the home. ❑ Full time ❑ Part time

_____ No, I am retired.

_____ No, I'm out of work at this time.

_____ No, I'm a full-time student.

_____ Yes, I work and I am a student ❑ Full time work ❑ Part time work

If you are not working at this time, are retired or not working for any other reason, please describe the type of work that you used to do.

If you are a student, please briefly describe your course of study and the school you attend:

QUESTIONS FOR INDIVIDUALS WHO ARE CURRENTLY WORKING:

Where do you work? Name of company/employer:

What is your job title?

Please describe the type of work that you do:

❑ My job is mostly sedentary, sitting, or working at a computer.

How many total hours a week do you work on the average? _____

Has medical illness, injury, or pain forced you to give up or change your type of work?

❑ Yes ❑ No

Have you ever missed work for the problem that you are coming here for?

❑ Yes ❑ No *If yes, please describe the details:*

Have you ever had a Worker's Compensation claim for any reason in the past?

❑ Yes ❑ No *If yes, please describe the detail of that injury:*

ETC.

Are you making this appointment because you are involved in a legal situation that requires a physician's evaluation or treatment? ❑ Yes ❑ No

FAMILY HISTORY:

Please use this form to complete this brief family history of diseases or illnesses.

	AGE (if living)	ILLNESSES	AGE (at death)	CAUSE OF DEATH
Mother				
Father				
Sisters				
Brothers				

FINALLY

Use the space below to provide any other information you think is important for me to know about you.

****Attach anything you think may be helpful, including previous medical records, photographs, copies of lab or x-ray tests, etc. . . .***