Dr. Alise Jones-Bailey
Health History Questionnaire

Patient Name:_____ DOB_____

I am primarily interested in: ❒Hormone Balancing ❒Sexual Dysfunction ❒Weight Loss ❒Fatigue/Chronic Fatigue ❒Nutrition Assessment
My Desired Goals:
List Allergies: (Medication, Food, Environmental)

Last Physical Exam Date:	List Surgeries/Dates:

Medical History Have you ever had or do you now:	Yes	No	Questions for Females Only	Yes	No
Tuberculosis			Treatment for gynecological (female) disorder?		
Shortness of breath			A change of menstrual pattern?		
A chronic cough or cough at night			Any abnormal Pap smears?		
Sinusitis/Hay fever			Do you have irregular periods?		
Thyroid trouble or goiter			Do you have any symptoms before your periods (i.e. PMS)		
Cataract or Glaucoma			Have your periods stopped? If yes, when?		
Numbness or tingling			How old were you when your periods first began?		
Stomach, liver, intestinal trouble or ulcer			How many times have you been pregnant?		
Gall bladder trouble or gallstones			How many live babies have you delivered?		
Jaundice or hepatitis (liver disease)			How many miscarriages have you had?		
Rectal disease, blood in stool			How many abortions have you had?		
			Questions for Females Only	**Yes**	**No**
			Palpitation, pounding heart or abnormal heartbeat		
			High or Low blood pressure		
			Depression or excessive worry		
Skin diseases (i.e. acne, eczema, psoriasis, etc)					
Frequent regularly or painful urination					
Adverse reaction to meds/antibiotics					
Recent unexplained weight gain or loss					
Dizziness or fainting spells					
Prolonged bleeding					

Initials_____

Health History Questionnaire – Page 2

Patient Name:_____

PREVENTIVE SERVICES ASSESSMENT	Never	< 1 year	1-2 years	3 + years
Flex Sigmoidoscopy/ Colonoscopy				
Rectal Exam				
Flu Shot				
Tetanus Shot				
Cholesterol Check				
Pneumovax (Pneumonia) Shot				
For Women Only)				
Pap Test				
Mammogram				
Breast Exam by a Physician				
For Men Only)				
Prostate Exam				
Testicular Exam				
PSA Check				

EXERCISE ASSESSMENT:
Approximate your weekly exercise routine. Circle the most accurate response for you.

In a week, how many times do you engage in aerobic exercise for 30 minutes or more?	____Never ____1-2 times/week ____3-4 times/week ____5 times/week ____more/week
How often do you exercise to build your strength, such as sit-ups, push-ups or weight training?	____Never ____1-2 times/week ____3-4 times/week ____5 times/week ____more/week

SEXUAL HEALTH ASSESSMENT:

This Assessment measures your attitude towards sex and sexuality. Study the following statements and choose the most accurate response for you.

Are you emotionally and physically satisfied with your sexuality? ____Yes ____No

In your lifetime, have you engaged in only heterosexual activity? ____Yes ____No

On average, how often do you have sexual intercourse? _____

STRESS ASSESSMENT

Please choose what you perceive is your stress level:

❑ Ideal ❑ Good ❑ Possible Problem

❑ Extreme

HORMONAL QUESTIONS DHEA	Yes	No	HORMANAL QUESTIONS SLEEP/MELATONIN	Yes	No
Thin and sparse pubic hair?			**Difficulty falling asleep?**		
Fatty lower abdomen?			Awaken at night and have difficulty returning to sleep?		
Ill-Being (non well-being)?			Feel un-rested upon waking in the morning?		
Lack of sexual attraction/ interest?			Tendency to sleep fewer hours per night?		

Initials_____

Health History Questionnaire – Page 3

Patient Name:_____

Large brown age spots?			I avoid mixing with people I don't know well		
Large white spots of de-pigmentation?			I feel as if I am a burden to people		
Eczema?			I often forget w2hat people have said to me		
HORMONAL QUESTIONS ESTROGEN (FEMALE ONLY)	**Yes**	**No**	I find it difficult to plan ahead		
Periods are irregular and painful?			I am easily irritated by other people		
Periods have stopped (menopausal)?			I often feel too tired to do the things I ought to do		
Lethargy, fatigue, memory loss?			I have to force myself to do all the things that need doing		
Vaginal dryness? Loss of libido?			I often have to force myself to stay awake		
Pain during intercourse?			My memory lets me down		
Excess body hair?			**HORMONAL QUESTIONS PROGESTERONE/ESTROGEN**	**Yes**	**No**
Small breasts?			Often constipated with infrequent bowel movements?		
Drooping, limp breasts?			Stools are hard and compact?		
Bladder infections?			Strain during bowel movements?		
Urinary incontinence?			Diarrhea?		
Hot flashes/Night sweats?			Bad breath?		
Tension, irritability, anxiety?			Indigestion, bloating or gas after eating?		
Headache?			Obesity?		
Joint pains, stiffness?			Yellow color to urine without the influence of B vitamins?		
Weight gain?			Urine is cloudy and unclear?		
Thinning hair?			Dandruff?		
Aging wrinkled skin?					

PERSONAL/FAMILY MEDICAL ASSESSMENT	**M=Me, S=Sister, B=Brother P=Parents, G-Grandparents Circle all that apply**					**SENSE OF WELL BEING**	**Yes**	**No**
Heart Disease	**M**	**S**	**B**	**P**	**G**	I need to generate excitement to avoid boredom.		
Stroke	**M**	**S**	**B**	**P**	**G**	I wake up earlier and cannot sleep.		
Asthma, Emphysema/COPD	**M**	**S**	**B**	**P**	**G**	I feel un-rested.		
Back Problems	**M**	**S**	**B**	**P**	**G**	I have trouble getting to sleep.		
Cancer	**M**	**S**	**B**	**P**	**G**	Things must be perfect.		
Chronic Fatigue Syndrome	**M**	**S**	**B**	**P**	**G**	I must do it myself.		
Diabetes	**M**	**S**	**B**	**P**	**G**	I must not fail.		

Health History Questionnaire – Page 4

Initials_____

Patient Name:_____

Migraines/Headaches	**M**	**S**	**B**	**P**	**G**	I cannot say "no" to new demands without feeling guilty.		
Immune System Disorder	**M**	**S**	**B**	**P**	**G**	I am unable to relax.		
Insomnia	**M**	**S**	**B**	**P**	**G**	I automatically express negative attitudes.		
Kidney Disorders	**M**	**S**	**B**	**P**	**G**	I am irritable, short-tempered, disappointed in the people around me.		
Arthritis/Bursitis	**M**	**S**	**B**	**P**	**G**	**LIFESTYLES ASSESSMENT**	**Yes**	**No**
TMJ	**M**	**S**	**B**	**P**	**G**	Cigarettes/How long?		
Viral and/or Bacterial Infections	**M**	**S**	**B**	**P**	**G**	Pipe/How long?		
Other:	**M**	**S**	**B**	**P**	**G**	Cigars/How long?		

YOUR EMOTIONAL STATE	**NONE**	**SOMETIMES**	**OFTEN**	Chewing Tobacco/How long?		
Muscle aches and tension				Overweight?		
Headaches or backaches				Average number of alcoholic drinks per week:		
Depression				The average number of business or social dinners eaten out per week:		
Poor memory				The number of caffeinated beverages/soda (coffee/tea/cola) drank each day:		
Boredom				The number of business lunches eaten each week:		
Lack of motivation				Number of overnight business trips per month:		
Sleep problems				Job title or responsibility:		
Nervous tics or habits				DO you typically take work home:	Yes	No
Anger				**JOB/WORKPLACE ASSESSMENT**	**Yes**	**No**
Frustration with self				The consequences are severe if I make a mistake at work		
Frustration with others				I frequently experience personal conflicts and/or harassment at work		
Lack of sense of humor				My job requires dealing with lots of red tape and frustration to get things done		
Inability to make decision				I can talk openly with management and my co-workers		

Initials_____

Patient Name:_____

SKIN ASSESSMENT (CHECK ALL THAT APPLY)	JOB/WORKPLACE ASSESSMENT (Continued	Yes	No
❑ Acne ❑ Pigmentation variances ❑ Acne scars ❑ Rosacea ❑ Oiliness/Dryness ❑ Fine lines ❑ Wrinkles ❑ Large pore size ❑ Loss of glow/vitality ❑ Pale, sallow appearance ❑ Discoloration ❑ Loss of skin tone ❑ Brown spots ❑ Sun damage ❑ Broken capillaries ❑ Spider Veins/Leg ❑ Veins ❑ Unwanted hair/whiskers ❑ Shaving ❑ Bumps ❑ Ingrown hair Have you seen anyone, i.e., dermatologist, plastic surgeon, spa facility? ❑ Yes ❑ No If yes, please provide approximate date(s) of service.	My company supports my efforts and rewards my contributions		
	I feel I deserve more compensation		
	I feel my job is at a dead end		
	My company has reasonable policies for sick time, vacation, health and other benefits		
	I am allowed a great deal of flexibility in my work schedule		
	I experience a great deal of change and uncertainty in my job		
	Other job/workplace comments:		

Initials_____

Patient Name:_____

Please list any other comments or concerns:

Initials_____