# HEALTH HISTORY QUESTIONNAIRE

**Name:**

**Physician's Name:**

**Date of last physical exam:**

## PERSONAL HEALTH HISTORY

### FAMILY & PERSONAL HISTORY

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a family history of sensitivity to chemicals, smoke or specific foods?</td>
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<tr>
<td>Do you have a family history of sensitivity to chemicals, perfumes, fragrances, smoke or foods?</td>
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<tr>
<td>Do you have a family or personal history of autoimmune diseases (i.e., SLE, MS, RA, Thyroiditis)?</td>
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<tr>
<td>Do you have a significant number of dental fillings?</td>
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<tr>
<td>Have you had synthetic materials put in your body? (i.e., prosthetics, implants)</td>
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<tr>
<td>Are you taking multiple medications - Over the counter or prescriptions?</td>
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<tr>
<td>Do you suffer from allergies or food sensitivities?</td>
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<tr>
<td>Do you have an autoimmune disease?</td>
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<tr>
<td>Do you suffer from low energy or excessive fatigue?</td>
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<td></td>
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<tr>
<td>If you were immunized, did you have any reactions or problems associated with those?</td>
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<tr>
<td>Do you suffer from muscle pain of unknown origin?</td>
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<tr>
<td>Do you have poor concentration or excessive forgetfulness?</td>
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<tr>
<td>Do you tend to catch &quot;every illness comes along&quot;?</td>
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<tr>
<td>Do you have Type 2 diabetes or Metabolic Syndrome?</td>
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<tr>
<td>Are you overweight even though you &quot;watch your diet&quot;?</td>
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### ENVIRONMENT & OCCUPATION

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
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<tbody>
<tr>
<td>Do you smoke?</td>
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<tr>
<td>Do you work in the chemical, paint or dye industry?</td>
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<tr>
<td>Do you have routine exposure to air pollution?</td>
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<tr>
<td>Are you an agricultural worker or routinely around plant products where biocides have been used?</td>
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<tr>
<td>Do you use soft plastic containers for food or water?</td>
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<tr>
<td>Are you exposed to household cleaning products on a routine basis?</td>
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</tbody>
</table>

### DIET & NUTRIENT INTAKE

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
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</tr>
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<tr>
<td>Do you routinely consume fast or packaged processed food?</td>
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<tr>
<td>Do you consume fish on a regular basis?</td>
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<tr>
<td>Do you regularly eat non-organic fruits and vegetables?</td>
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<tr>
<td>Do you consume a high animal product diet (i.e. milk, meat, cheese, and eggs)?</td>
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</tbody>
</table>
Name ___________________________ Date __________________
Address __________________________ City __________________________ State ____ Zip Code ________
Phone ___________________________ Email __________________________
Occupation __________________________ Age ___ Height ___ Sex ___ Number of Children ________
Marital Status: □ Single □ Partner □ Married □ Separated □ Divorced □ Widow
Are you recovering from a cold or flu? ______________ Are you pregnant? ______________
Reasons for office visit: __________________________ Date began: __________________________

What types of therapies have you tried for these problem(s) or to improve your health overall:
□ diet modification □ fasting □ vitamins/minerals □ herbs □ homeopathy □ chiropractic □ acupuncture
□ conventional drugs □ other __________________________

Do you experience any of these general symptoms every day?
□ Debilitating fatigue □ Shortness of breath □ Insomnia □ Constipation □ Chronic pain/inflammation
□ Depression □ Panic attacks □ Nausea □ Fecal incontinence □ Bleeding
□ Disinterest in sex □ Headaches □ Vomiting □ Urinary incontinence □ Discharge
□ Disinterest in eating □ Dizziness □ Diarrhea □ Low grade fever □ Itching/rash

Current medications (prescription or over-the-counter): __________________________
________________________________________

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):
________________________________________
________________________________________
Outcome __________________________
________________________________________

Major Hospitalization, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:
Year __________________________ Surgery, Illness, Injury __________________________ Outcome __________________________
________________________________________
________________________________________
________________________________________
________________________________________

Circle the level of stress you are experiencing in a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10
Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): __________________________
Do you consider yourself: □ underweight □ overweight □ just right Your weight today __________________________
Have you had an intentional weight loss or gain of 10 pounds or more in the last three months? __________________________

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)? __________________________

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 problem
- Colitis
- 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 date of last GYN exam
- Mammogram
- PAP
- Form of birth control
- # of children
- # of pregnancies
- C-section
- Age of first period
- Date - Last menstrual cycle
- Length of cycle
- Interval of time between cycles
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)
- Surgical menopause
- Menopause

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 problems (Parkinson’s, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other

Health Habits

- Tobacco:
  - Cigarettes #/day
  - Cigars #/day
- Alcohol:
  - Wine: #glasses/d or wk
  - Liquor: #ounces/d or wk
  - Beer: #glasses/d or wk
- Caffeine
- Coffee: #6 oz. cups/d
- Tea: #6 oz. cups/d
- Soda w/ caffeine: #cans/d
- Other sources
- Water: #glasses/d

Exercise

- 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/workout
- Less than 30 minutes
- Walk: #days/wk
- Run, jog, other aerobic: #days per wk
- Weight lift - #days/wk
- Stretch - #days/wk
- Other

Nutrition and Diet

- Mixed food diet (animal & 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
- Ill gluten
- Other

Food Frequency

Number of 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 meals - which ones
  - One meal/day
  - Two meals/day
  - Three meals/day
  - Graze (small frequent meals)
  - Generally eat on the run
  - Eat constantly whether hungry or not

I Would Like To:

- ENERGY - VITALITY
  - Feel more vital
  - Have more energy
  - More endurance
  - Be less tired after lunch
  - Sleep better
  - Be free of pain
  - Get less colds and flu
  - Get rid of allergies
  - Not be dependent on over-the-counter medications like aspirin ibuprofen, antihistamines, sleeping aids, etc.
- Stop using laxatives and stool softener

- BODY COMPOSITION
  - Lose weight
  - Burn more body fat
  - Be stronger
  - Have better muscle tone
  - Be more flexible

- STRESS, MENTAL, EMOTIONAL
  - Learn how to reduce stress
  - Think more clearly and be more focused
  - Improve memory
  - Be less depressed
  - Be less moody
  - Be less indecisive
  - Feel more motivated

- LIFE ENRICHMENT
  - Reduce my risk of degenerative disease
  - Slow down accelerated aging
  - Maintain a healthier life longer
  - Change from a “treating-illness” orientation to creating a wellness lifestyle

Other

Current supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA / DHA
- Evening Primrose (GLA)
- Calcium, source
- Magnesium
- Zinc
- Minerals, describe
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., Lutein, resveratrol, etc.)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (bee pollen, phytounit nutrients)
- Liquid meals
- Other