Points of Wellness LLC

Health History Questionnaire

Date: _____/_____/_____

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential, unless you sign a waiver allowing your records to be released.

Name:		Home phone:		Work phone:	Cell phone:
Address:		City:	State:	Zip code:	Referred by:
Sex: □ female □ male	Age:	Date of Birth:	Email address: (Is it ok to contact you by email? Y / N)		
Marital status: □ married □ divorced □ single □ separated □ widowed □ living with partner			Occupation:		
Education: (highest level achieved) □ high school graduate □ college graduate □ graduate school or professional school			Family physician and phone number:		
In case of emergency contact:			Emergency contact phone:		

What is/are the main problem(s) you would like us to help you? _____

_____

How long ago did this problem begin_____

Was there a known cause/instigating factor for your problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex)?_____

_____

Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatment have you tried for this problem? _____

_____

Past medical history:

□ Cancer_____ □ Diabetes____ □ Hepatitis____ □ High Blood Pressure____ □ Heart Disease
□ Rheumatic Fever_____ □ Thyroid Disease____ □ Seizures_____ □ Venereal Disease_____
□ asthma_____ □ stroke _____
□ other_____

Surgeries (type and date): _____

_____

Significant Trauma (auto accident, falls, etc. and date): _____

Significant Dental work (type and date): _____

Patient Birth History (prolonged labor, premature, forceps delivery, etc.): _____

Allergies (drugs, chemicals, foods, etc. and reaction): _____

_____

Family medical history (check all that apply):

□ Diabetes □ Cancer □ High blood pressure □ Heart disease □ Stroke
□ Seizures □ Asthma □ Allergies
□ other: _____

Medicines taken within the last two months (vitamins, drugs, aspirin, home remedies, herbs, etc.): _____

_____

Occupational exposures and stress (chemical, physical, psychological, etc.): _____

_____

Do you have a regular exercise program? □ yes □ no What kind? _____

In a typical day, what do you normally eat?

Morning: _____

Afternoon: _____

Evening: _____

Snacks (what type & time of day): _____

How much do you drink per week of: coffee ____ tea ____ soda ____ alcohol ____
Do you smoke? Y/N

Please check any symptoms that have been persistent in the last 3-6 months

General

□ chills □ fevers □ night sweats □ localized weakness □ poor sleeping
□ bruise easily □ strong thirst □ fatigue □ sudden drop in energy □ edema
□ tremors □ poor balance □ cravings □ change in appetite □ weight loss/gain

Skin and hair

□ rashes □ itching □ ulcerations □ changes in hair/skin □ hives
□ eczema □ pimples □ recent moles □ loss of hair □ dandruff

Head, eyes, ears, nose and throat

□ dizziness □ facial pain □ migraines □ headaches □ glasses
□ night blindness □ blurry vision □ spots in vision □ eye pain □ cataracts
□ dry eyes □ tearing □ poor hearing □ ringing in ears □ earaches
□ nose bleeds □ nasal discharge □ congestion □ teeth grinding □ jaw clicks
□ sore throats □ sores on lips □ mouth sores

Please check any symptoms that have been persistent in the last 3-6 months

Cardiovascular

□ high blood pressure □ low blood pressure □ chest discomfort/pain □ heart palpitations
□ cold hands or feet □ swelling of hands or feet □ blood clots □ fainting
□ difficulty breathing

Respiratory

□ cough □ asthma/wheezing □ pain with deep breath □ coughing blood
□ pneumonia □ bronchitis □ difficulty breathing when lying down
□ production of phlegm (what color?_____)

Gastrointestinal

□ bad breath □ nausea □ vomiting □ heartburn □ belching □ indigestion
□ diarrhea □ constipation □ blood in stool □ black stool □ gas □ abdominal pain/cramps
□ rectal pain □ hemorrhoids

Genito-urinary

□ pain on urination □ urgency to urinate □ frequent/decreased urination □ blood in urine
□ unable to hold urination □ dribbling □ kidney stones □ sores on genitals
□ do you wake up to urinate □ prostate trouble □ impotency

Pregnancy and gynecology

□ number of pregnancies____ □ number of births____ □ number of miscarriages____
□ number of abortions____ □ age at first menses_____□ days between menses_____
□ duration of menses____ □ first date of last menses__/___/___ □ painful periods
□ irregular periods □ clots □ menopause: age___ year_____
□ vaginal discharge □ vaginal sores □ last pap smear___/___/___
□ breast lumps □ nipple discharge □ do you practice birth control Y/N

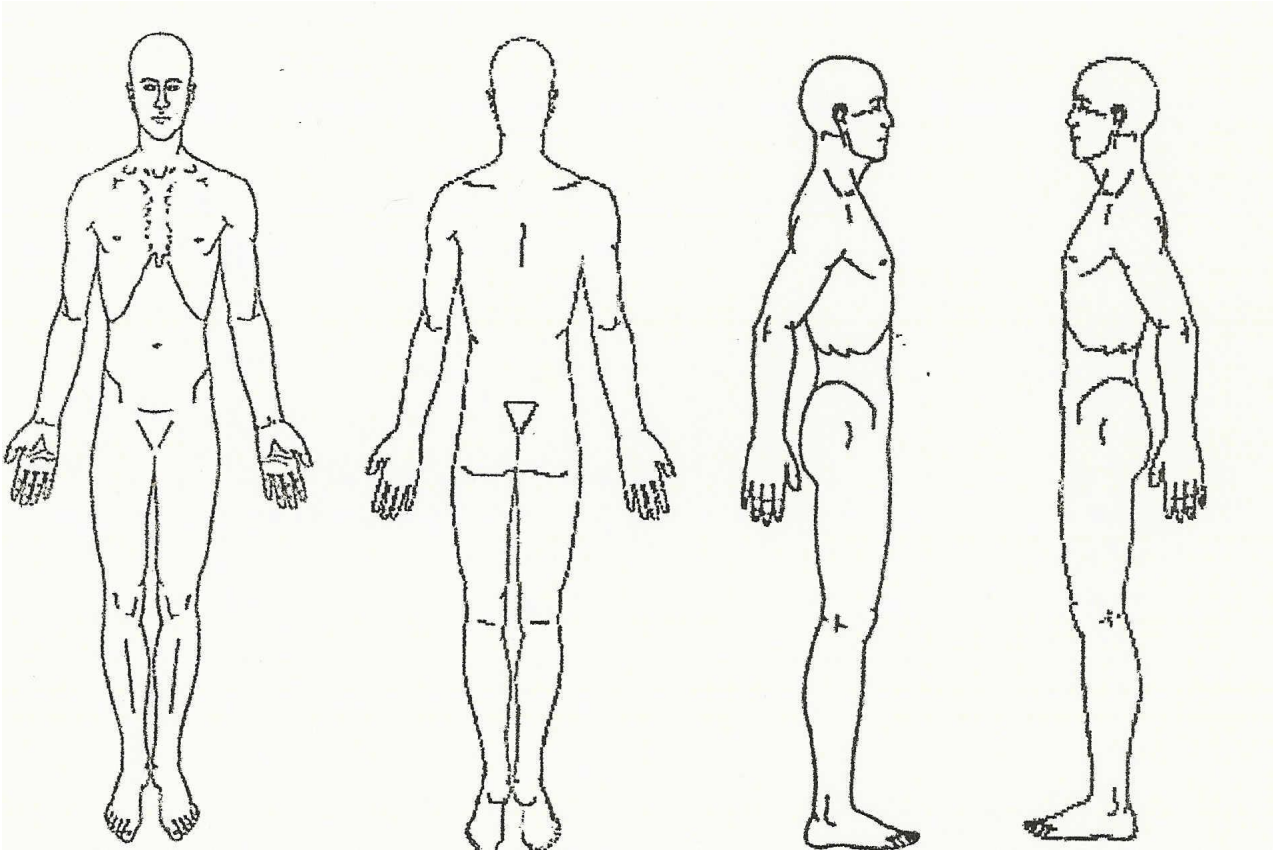
Musculoskeletal

□ neck pain □ shoulder pain □ back pain □ elbow pain □ hand/wrist pain
□ hip pain □ knee pain □ foot/ankle pain □ muscle pain □ muscle weakness

Neuropsychological

□ seizures □ areas of numbness □ weakness □ sleep disorder □ concussion
□ bad temper □ loss of control/violent □ vertigo □ lack of coordination
□ depression □ loss of balance □ poor memory □ anxiety □ substance abuse
□ ever been treated for emotional disorders □ ever considered or attempted suicide

Please mark below on the pictures all the problem areas using **P** for pain, **N** for numbness, **T** for tightness, **X** for tingling



Please list any additional information which would help us better understand your condition

_____

_____