HEALTH QUESTIONNAIRE

Today's Date: _____

Name (Last, First, MI):			**Home Phone #:**
Birth Date: / / **Month Day Year**	**Gender:**	**Marital Status:** **M S D**	**Cell Phone #:**
Address: **(Street)** **(City)** **(ZIP)**			**Work Phone #:**
Email Address:			☐ **OK to Contact Me via email**
Referred By:			☐ **NOT OK to Contact via email**

Emergency Contact Name:	**Emergency Contact Phone #:**
Primary Physician's Name:	**Primary Physician's Phone #:**
Preferred Pharmacy Name:	**Pharmacy Phone #:**

HISTORY

Reason for Consultation: _____

Health Concerns/Symptoms: _____

_____

Desired Outcome of Consultation: _____

Are you currently under the care of a healthcare professional for a medical or health condition? ☐ No ☐ Yes

If "Yes," please describe condition (s): _____

_____

Name: _____

MEDICATION/SUPPLEMENTATION

List Current Medications (or those you have taken within the last year). Attach a separate page if more room is needed.

Medication Name	Date Started	Date Stopped	Dose/amt. Daily

Nutritional Supplements, Vitamins, Herbs, Homeopathic Remedies Taken

Medication Allergies

Environmental or Food Allergies

Name: _____

PAST MEDICAL HISTORY

Please check any medical conditions or health problems that you currently have, or have had in the past:

Condition	Yes	No
Headaches (Migraines)		
Seizure Disorder		
Recurrent Sinus Infections		
Seasonal Allergies		
Emotional/Psychiatric Illness		
Depression		
Anxiety/Excessive Stress		
Asthma		
Chronic Bronchitis		
Lung/Breathing Problems		
Chronic Indigestion		
Stomach Ulcers		
Intestinal Disease		
Skin Problems		
Back Pain/Sciatica		
Herniated Disc		
Neck Pain		
Chronic Muscle/Joint Pain		
Carpal Tunnel Syndrome		
Fibromyalgia		
Diabetes		
Thyroid Disease		
Osteoporosis		

Condition	Yes	No
Heart Disease		
Chest Pain		
Irregular Heart Beat		
High Blood Pressure		
Blood Clotting Problems		
Bleeding Disorder		
Stroke/Vascular Disease		
Constipation/Diarrhea		
Hepatitis/Liver Disease		
Kidney Disease		
Menstrual Disorders		
Reproductive Problems		
Prostate Problems		
Sexual Libido Problems		
Tendonitis		
Chronic Pain		
Shoulder Problems		
Osteoarthritis		
Rheumatoid Arthritis		
Artificial Joint (s)		
Cancer		
Psoriasis or Eczema		
Other (please list below)		

Other problems not listed above: _____

_____

Preventive Tests	Month/Year of Last Test	Test Results
Cholesterol		
Bone Density		
Colonoscopy		
Exercise Stress Test		

List any surgeries/procedures you have had done, and when:

Surgery or Procedure	Date

Name: _____

SYMPTOM CHECKLIST FOR WOMEN

Category 1: Basic Hormone Imbalance

Mark which of the following factors/symptoms are present and/or persist over time.

	Hot Flashes		Mood Swings (PMS)		Urinary Incontinence		Night Sweats
	Heart Palpitations		Cystic Ovaries		Vaginal Dryness		Acne
	Heavy Menses		Foggy Thinking		Weight Gain		Depressed Mood
	Fibrocystic Breasts		Irritability		Increased Body/Facial Hair		Headaches
	Low Libido/Decreased Sexual Function		Uterine Fibroids				Bone Loss

Category 2: Adrenal Hormone Imbalance

Mark which of the following factors/symptoms are present and/or persist over time.

	Aches & Pains		Weight Gain		Morning Fatigue		Food Cravings
	Sleep Disturbances		Depression		Anxiety		Susceptibility to Infections
	Chronic Health Problems		Evening Fatigue		Allergies		Autoimmune Diseases
	Low Blood Sugar		History of Steroid Usage		Bone Loss		Diabetes or Prediabetes

Category 3: Thyroid Hormone Imbalance

Mark which of the following factors/symptoms are present and/or persist over time.

	Aches & Pains		Anxiety		Brittle Nails		Depression
	Dry Skin		Cold Hands & Feet		Headaches		Infertility
	Fatigue		Foggy Thinking		Weight Gain		Feeling Cold All the Time
	Heart Palpitations		Low Libido		Inability to Lose Weight		Sleep Disturbances
	Constipation		Thinning Hair		Menstrual Irregularities		Elevated Cholesterol

Category 4: Cardiometabolic Risk

Mark which of the following factors/symptoms are present and/or persist over time.

	History of Smoking		Weight Gain		Heart Disease or Family History of Heart Disease
	High Blood Sugar		Sugar Cravings		Diabetes or Family History of Diabetes
	High Blood Pressure		Fatigue		Waist Size Greater than 35 Inches
	Elevated Triglycerides		Low Physical Activity		

Name: _____

SYMPTOM CHECKLIST FOR MEN

Category 1: Basic Hormone Imbalance

Mark which of the following factors/symptoms are present and/or persist over time.

	Burned Out Feeling		Irritable		Insomnia		Decreased Urine Flow
	Hot Flashes		Erectile Dysfunction		Increased Urinary Urge		Decreased Stamina
	Weight Gain / Waist		Prostate Problems		Infertility Problems		Sleep Disturbances
	Decreased Libido		Decreased Mental Sharpness		Oily Skin		Decreased Muscle Mass
	Decreased Erections		Night Sweats		Apathy		

Category 2: Adrenal Hormone Imbalance

Mark which of the following factors/symptoms are present and/or persist over time.

	Aches & Pains		Depression		Morning Fatigue		Bone Loss
	Sleep Disturbances		Lack of Motivation		Anxiety		Low Blood Sugar
	Chronic Health Problems		Prostate Problems		Allergies		Autoimmune Diseases
	Stress		Evening Fatigue		Weight Gain / Waist		Fibromyalgia
	Decreased Erections		Susceptibility to Infections				

Category 3: Thyroid Hormone Imbalance

Mark which of the following factors/symptoms are present and/or persist over time.

	Low Libido		Depression		Feeling Cold		Decreased Erections
	Foggy Thinking		Infertility		Headaches		Sleep Disturbances
	Constipation		Fatigue		Lack of Motivation		Inability to Lose Weight
	Elevated Cholesterol		Dry Skin		Heart Palpitations		Brittle Nails

Category 4: Cardiometabolic Risk

Mark which of the following factors/symptoms are present and/or persist over time.

	History of Smoking		Weight Gain		Heart Disease or Family History of Heart Disease
	High Blood Sugar		Sugar Cravings		Diabetes or Family History of Diabetes
	High Blood Pressure		Fatigue		Waist Size Greater than 40 Inches
	Low Physical Activity		Elevated Triglycerides		

Name: _____

FAMILY HISTORY

For the conditions listed, check **Yes** or **No** if anyone in your family has been affected, then write the relationship of that relative, such as "sister" or "father" on the adjacent line

Condition	No	Yes	Relationship
Heart Disease			
High Blood Pressure			
Diabetes			
Arthritis			
Skin Disorders			
Breast Cancer			
Uterine/Ovarian Cancer			
Prostate Cancer			
Colon Cancer			
Other Cancer			
Other Disease or Condition			

MEN

Date of Last Prostate Exam: _____ Results: ☐ Normal ☐ Abnormal

Question	No	Yes
Are you concerned with any loss of muscle mass, tone, or strength?		
Have you had problems with urination (decreased stream/frequent night urination)?		
Do you perform periodic testicular self-examination?		
Has your abdominal girth and weight been increasing?		

WOMEN

Date of last PAP/Pelvic/Breast exam: _____ Results: ☐ Normal ☐ Abnormal

Date of last Mammogram: _____ Results: ☐ Normal ☐ Abnormal

Date of last Menstrual Cycle: _____

Question	No	Yes
Are you pregnant?		
Have you had a hysterectomy?		
Were your ovaries removed?		
Do you perform monthly self-exams?		
Are you currently taking or have you taken oral contraceptives?		
Are you currently taking or have you taken hormones?		
If yes to either of the above, list what you took and when:		
List any problems or concerns about taking hormone replacement therapy:		
Describe any menstrual irregularities:		
How many pregnancies? (list number)		
How many children do you have? (list number)		

Name: _____

SOCIAL HISTORY/PERSONAL HEALTH HABITS

Check the applicable answer:

Question	Excellent	Good	Fair	Poor
My health is:				
My nutritional intake is:				
My physical fitness is:				

Check all that apply:

Question	A Lot of Stress	Often Fatigued	Often Sad/Blue	Often Have Trouble Dealing with Stress
My Stress level is:				

Check the applicable answer:

Do you regularly practice meditation or other stress reducing techniques? ☐ **No** ☐ **Yes**

Dietary Habits - Check all that apply:

	No special dietary habits.		I commonly eat pre-packaged foods.
	Vegetarian		I commonly eat at fast-food restaurants.
	Avoid Red Meat		I commonly consume coffee.
	Emphasize Fruits and Vegetables		I commonly consume soft drinks.
	Minimize Fat		I commonly consume diet drinks.
	Try to Eat Healthy		I commonly consume candy/chocolate/other desserts.
	Minimize Carbohydrates		I commonly consume chips/crackers.
	Avoid Dairy/Cheese		Other (list)

Exercise Habits – Check all that apply:

	No special exercise habits.		I routinely exercise.
	Aerobic Exercise		I exercise hours per week. (fill in number)
	Strength Training/Weights		I exercise times per week. (fill in number)
	Swim		Walk times per week. (fill in number)
	Dance		Run times per week. (fill in number)
	Stretch for Flexibility (yoga, tai'chi)		I seldom exercise.
	Other exercise: (list)		

Tobacco History – Check all that apply:

	I have never smoked cigarettes or chewed tobacco.
	I now smoke packs of cigarettes per day. (fill in number)
	I have smoked for years. (fill in number)
	I quit smoking in (fill in month/year).
	I smoked packs a day for years. (fill in numbers)
	I smoke cigars/pipe.

Alcohol History – Check all that apply:

	I never drink alcohol.
	I drink occasionally or socially.
	I regularly drink alcoholic drinks per day. (fill in number)
	I have a family history of alcoholism.

Hobbies/Recreation – List Activities

_____