1015 Mark Avenue • Carpinteria, CA 93013
1.800.892.4772 (toll-free) • 1.805.745.8111 (international)
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# Medical History and Present Medical Condition Questionnaire



| Name | Date |
|---|---|

In order for you to gain the most benefit from this program, we encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, feel free to leave it blank. Please explain all YES answers at the end of this questionnaire.

**PERSONAL MEDICAL HISTORY**

Have you have ever had any of the following conditions?

| Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|
| | | 1. Allergies | | | 11. Ulcer | | | 21. Loss of consciousness |
| | | 2. Loss of hearing | | | 12. Heart attack | | | 22. Epilepsy |
| | | 3. Asthma | | | 13. Heart murmur | | | 23. Convulsions/seizures |
| | | 4. Kidney disease | | | 14. Positive stress test | | | 24. Stroke |
| | | 5. Prostatitis | | | 15. Heart valve abnormality | | | 25. Diabetes |
| | | 6. Colitis | | | 16. Angina | | | 26. Thyroid trouble |
| | | 7. Hepatitis | | | 17. Heart failure | | | 27. Anemia |
| | | 8. Liver disease | | | 18. High cholesterol | | | 28. Eczema |
| | | 9. Elevated liver enzyme test | | | 19. High blood pressure | | | 29. Cancer (including skin cancer) |
| | | 10. Pancreatitis | | | 20. Arthritis/Rheumatism | | | 30. Sleep apnea |

**REVIEW OF SYMPTOMS**

Do you currently have or have you recently had any of the following?

| EYES, EARS, NOSE, THROAT | | | PULMONARY | | | GENITO-URINARY | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | | Y | N | | Y | N | |
| | | 31. Difficulty with night vision | | | 40. Shortness of breath | | | 45. Bladder trouble |
| | | 32. Change in vision | | | 41. Chronic or frequent cough | | | 46. Blood in urine |
| | | 33. Blurred or double vision | | | 42. Brown/Blood-tinged sputum | | | 47. Irregular vaginal bleeding |
| | | 34. Bleeding gums | | | 43. Chest tightness | | | 48. Currently pregnant |
| | | 35. Frequent nosebleeds | | | 44. Wheezing | | | 49. Difficulty starting or stopping urination |
| | | 36. Frequent sinus trouble | | | | | | |
| | | 37. Recent Hoarseness | | | | | | 50. Urinating 3 times per night |
| | | 38. Ringing/Buzzing ears | | | | | | 51. Frequent or painful urination |
| | | 39. Earaches | | | | | | 52. Problems with sexual function |

| GASTROINTESTINAL | | | CENTRAL NERVOUS SYSTEM | | | HEART/VASCULAR | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | | Y | N | | Y | N | |
| | | 53. Vomited blood | | | 63. Fainting spells | | | 71. Palpitation (irregular heartbeat) |
| | | 54. Persistent diarrhea | | | 64. Recurrent dizziness | | | 72. Pain or discomfort in chest |
| | | 55. Persistent constipation | | | 65. Frequent headaches | | | 73. High cholesterol |
| | | 56. Frequent abdominal pain | | | 66. Tremors | | | 74. Swelling of feet |
| | | 57. Frequent nausea | | | 67. Memory loss | | | 75. Leg pain while walking |
| | | 58. Frequent indigestion/heartburn | | | 68. Loss of coordination | | | 76. Painful varicose veins |
| | | 59. Black/Bloody bowel movement | | | 69. Difficulty concentrating | | | |
| | | 60. Hemorrhoids | | | 70. Numbness/Tingling extremities | | | |
| | | 61. Trouble swallowing | | | | | | |
| | | 62. Hernia | | | | | | |

| MUSCULOSKELETAL. | | | MISCELLANEOUS | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | | Y | N | | Y | N | |
| | | 77. Back trouble/pain | | | 81. Bleeding/Bruising easily | | | 86. Night sweats |
| | | 78. Neck trouble/pain | | | 82. Enlarged glands | | | 87. Undesired weight loss |
| | | 79. Joint injury/pain/swelling | | | 83. Rashes | | | 88. Snoring |
| | | 80. Carpal tunnel syndrome | | | 84. Unexplained lumps | | | 89. Difficulty sleeping |
| | | | | | 85. Chronic fatigue | | | 90. Low blood sugar |

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Name

**ADDITIONAL HEALTH AND LIFESTYLE QUESTIONS**

Please answer the following questions honestly:

| Y | N | |
|---|---|---|
| | | 91. Are you experiencing any stresses, mood problems, relationship difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis? |
| | | 92. Do you occasionally use or are you currently taking any prescription or over-the-counter medications? List name, dosage, and the reason the medication is used on the next page. |
| | | 93. Have you had any surgical operations in the last 10 years? |
| | | 94. Has anyone in your immediate family developed heart disease before the age of 60? |
| | | 95. Do any diseases run in your family? |
| | | 96. Do you currently have a cold/cough, or have you had any in the last two weeks? |
| | | 97. Have you ever been hospitalized? If yes, list date, length of stay, and reason on the next page. |
| | | 98. Are you currently under a doctor's care? If yes, please describe what you are being treated for on the next page. |
| | | 99. Have you had a change in the size or color of a mole, or a sore that would not heal in the past year? |
| | | 100. Do you have any special concerns regarding your health that you would like to discuss with the doctor? |
| | | 101. Are you a current cigarette smoker?<br>A. How many packs of cigarettes do you smoke a day? ________<br>B. How long have you been smoking? ________ |
| | | 102. Are you an ex-smoker?<br>A. How many years did you smoke? ________<br>B. How many packs a day? ________<br>C. When did you quit? ________ |

103. Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?

104. I drink ____ beers ____ ounces of hard liquor ____ ounces of wine per week.

105. When were your most recent immunizations? Tetanus ________ Flu shot __________ Pneumovax __________

106. When were you most recent health maintenance screening tests?

Cholesterol ________ Results? ________ PSA (Prostate) ________ Results? ________ Mammogram ________ Results? ________

Sigmoidoscopy ________ Results? ________ Pap Smear ________ Results? ________

107. Describe any hobbies or recreational activities that have exposed you to noise, chemicals, or dust:

108. Please describe typical weekly exercise or physical activities including any exercise at work:

109. My current diet could be best characterized as (check all that apply):

____ Low fat ___ Low carb ___ High protein ___ Vegetarian/Vegan ____No special diet

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Name

Please Explain All YES Answers Here. List the question number, and add details.

| QUESTION NUMBER | DETAILS AND DATES OF OCCURRENCE |
|---|---|
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