Health History Questionnaire

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss	Last Name	First
Street Apt#	City	State/ Zip Code
DOB (MM/DD/YYYY)	Social Security #	Home Phone #
Business Phone #	Cell Phone #	Fax #
E-mail Address	I am primarily interested in: ☐ Hormone Balancing ☐ Fatigue/Chronic Fatigue ☐ Nutrition Assessment	
Referred By: ☐ Print Ad ☐ Television ☐ Radio ☐ Internet ☐ Newspaper ☐ Friend ☐ Other		
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**
Tuberculosis		
Shortness of breath		
A chronic cough or cough at night		
Sinusitis/Hay fever		
Thyroid trouble or goiter		
Cataract or Glaucoma		
Numbness or tingling		
Stomach, liver, intestinal trouble, or ulcer		
Gall bladder trouble or gallstones		
Jaundice or hepatitis (liver disease)		
Rectal disease, blood in stool		
Skin diseases (i.e. acne, eczema, psoriasis, etc)		
Frequent or painful urination		
Adverse reaction to meds/antibiotics		
Recent unexplained wt gain or loss		
Dizziness or fainting spells		
Prolonged bleeding		
Palpitation, pounding heart or abnormal heartbeat		
High or low blood pressure		
Depression or excessive worry		

Questions for Females Only	**Yes**	**No**
Treatment for gynecological (female) disorder?		
A change of menstrual pattern?		
Any abnormal Pap smears?		
Do you have irregular periods ?		
Do you have any symptoms before your periods (i.e.: PMS)		
Have your periods stopped? If yes, when?		
How old were you when your periods first began?		
How many times have you been pregnant?		
How many live babies have you delivered?		
How many miscarriages have you had?		
How many abortions have you had?		

MEDICATION LIST: Please list all prescriptions/supplements/herbals taken regularly	

PREVENTATIVE SERVICES ASSESSMENT	Never	< 1 year	<1-2 year	<10 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 1-2x/wk 3-4x/wk 5x/wk-more/wk
How often do you do exercises to build your strength, such as sit-ups, push-ups, or weight training?	Never 1-2x/wk 3-4x/wk 5x/wk-more/wk

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?

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

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	Y	N
Thin and sparse pubic hair?		
Fatty lower abdomen?		
Ill-Being (non well-being)?		
Lack of sexual attraction/interest?		
Frequent Illness/Depressed Immune system?		

INCREASED TESTOSTERONE ➔ESTROGEN CONVERSION	Y	N
Poor flexibility?		
Decreased muscle strength?		
Excess fat on breasts?		
Fat on belly?		
Fat on hips and buttocks?		
Cellulite (thighs/buttocks)?		
Varicose veins?		
Dry eyes?		
Loss of drive to succeed?		
Poor self image?		
Depression?		
Overly emotional?		
Poor memory ?		
Poor concentration?		

HORMONAL QUESTIONS SLEEP/MELATONIN	Y	N
Difficulty falling asleep?		
Awaken at night and have difficulty returning to sleep?		
Feel unrested upon waking in the morning?		
Tendency to sleep fewer hours per night?		
Other:		

HORMONAL QUESTIONS THYROID	Y	N
Sensitive to cold, need extra blankets during winter?		
Cold hands or feet		
Lack of energy?		
Depressed?		
Poor memory?		
Poor concentration?		
Tendency to gain weight?		
Constipation (slow, difficult digestion)?		
Swollen hands or feet?		
Dry skin (face, elbows, legs)?		
Lack of perspiration during physical activity?		
Finger nails (brittle/slow growing)?		
Slow hair growth?		

HORMONAL QUESTIONS CORTISOL	Y	N
Shortness of breath?		
Allergic reactions, sneezing, runny nose, sore throat?		
Need 20 minutes to one hour daily for nap or quite time?		
Dizzy when standing up?		
Low blood pressure?		
Fast beating heart in stressful situations?		
Low resistance to stress?		
Feel better after eating something sweet?		
Crave salty or spicy foods?		
Digestive problems?		
Nausea?		
Underweight?		
Inflammatory arthritis?		
Intolerance to medications?		
Food allergies?		
Allergic symptoms present in nose, throat, ears and/or skin?		
Large brown age spots?		
Large white spots of de-pigmentation?		
Eczema?		

HORMONAL QUESTIONS ESTROGEN (FEMALE ONLY)	Y	N
Periods are irregular and painful?		
Periods have stopped (menopausal)?		
Lethargy, fatigue, memory loss?		
Vaginal dryness? Loss of Libido?		
Pain during intercourse?		
Excess body hair?		
Small breasts?		
Drooping, limp breasts?		
Bladder infections?		
Urinary incontinence?		
Hot flashes/Night Sweats?		
Tension, irritability, anxiety?		
Headache?		
Joint pains, stiffness?		
Weight gain?		
Thinning hair?		
Aging wrinkled skin?		

HORMONAL QUESTIONS GROWTH HORMONE	Y	N
I have to struggle to finish jobs		
I feel a strong need to sleep during the day		
I often feel lonely even when I am with other people		
I have to read things several times before they sink in		
It is difficult for me to make friends		
It takes a lot of effort for me to do simple tasks		
I have difficulty controlling my emotions		
I often lose track of what I want to say		
I lack confidence		
I have to push myself to do things		
I often feel very tense		
I feel as if I let people down		
I find it hard to mix with people		
I feel worn out even when I've not done anything		
There are times when I feel very low		
I avoid responsibility if possible		
I avoid mixing with people I don't know well		
I feel as if I am a burden to people		
I often forget what people have said to me		
I find it difficult to plan ahead		
I am easily irritated by other people		
I often feel too tired to do the things I ought to do		
I have to force myself to do all the things that need doing		
I often have to force myself to stay awake		
My memory lets me down		

HORMONAL QUESTIONS PROGESTERONE/ESTROGEN	Y	N
Often constipated with infrequent bowel movements?		
Stools are hard and compact?		
Strain during bowel movements?		
Diarrhea?		
Bad breath?		
Indigestion, bloating or gas after eating?		
Obesity?		
Yellow color to urine without the influence of B vitamins?		
Urine is cloudy and unclear?		
Dandruff?		

PERSONAL/FAMILY MEDICAL ASSESSMENT	M= Me, S=Sister, B=Brother P=Parents, G=Grandparents Circle all that apply				
Heart Disease	M	S	B	P	G
Stroke	M	S	B	P	G
Asthma/Emphysema/COPD	M	S	B	P	G
Back Problems	M	S	B	P	G
Cancer	M	S	B	P	G
Chronic Fatigue Syndrome	M	S	B	P	G
Diabetes	M	S	B	P	G
Migraines/Headaches	M	S	B	P	G
Immune System Disorder	M	S	B	P	G
Insomnia	M	S	B	P	G
Kidney Disorders	M	S	B	P	G
Arthritis/Bursitis	M	S	B	P	G
TMJ	M	S	B	P	G
Viral &/or Bacterial Infections	M	S	B	P	G
Other:	M	S	B	P	G

YOUR EMOTIONAL STATE	NONE	SOMETIMES	OFTEN
Muscle aches and tension			
Headaches or backaches			
Depression			
Poor memory			
Boredom			
Lack of motivation			
Sleep problems			
Nervous tics or habits			
Anger			
Frustration with self			
Frustration with others			
Lack of sense of humor			
Inability to make decision			

SENSE OF WELL BEING	Y	N
I need to generate excitement to avoid boredom.		
I wake up earlier and cannot sleep.		
I feel unrested.		
I have trouble getting to sleep.		
Things must be perfect.		
I must do it myself.		
I must not fail.		
I cannot say “no” to new demands without feeling guilty.		
I am unable to relax		
I automatically express negative attitudes		
I am irritable, short-tempered, disappointed in the people around me		

Lifestyles Assessment	**Y**	**N**
Cigarettes/How Long?		
Pipe/How Long?		
Cigars/How Long?		
Chewing Tobacco/How Long?		
Overweight?		

Average number of **alcoholic drinks** per week.

The average number of business or **social dinners** eaten out per week:

The number of **caffeinated** beverages/soda (coffee/tea/cola/) drank each day:

The number of **business lunches** eaten each week:

Number of **overnight business trips** per month:

Job title or responsibility:

Do you typically take work home?	**Y**	**N**

JOB/WORKPLACE ASSESSMENT:	**Y**	**N**
The consequences are severe if I make a mistake at work		
I frequently experience personal conflicts and/or harassment at work		
My job requires dealing with lots of red tape and frustration to get things done		
I can talk openly with management and my co-workers		

SKIN ASSESSMENT (Check all that apply)	**JOB/WORKPLACE ASSESSMENT (Continued):**	**Y**	**N**
☐ Acne ☐ Pigmentation variances	My company supports my efforts and rewards my contributions		
☐ Acne scars ☐ Rosacea	I feel I deserve more compensation		
☐ Oiliness/Dryness ☐ Fine lines	I feel my job is at a dead end		
☐ Wrinkles ☐ Large pore size	My company has reasonable policies for sick time, vacation, health and other benefits		
☐ Loss of glow/vitality ☐ Pale/sallow appearance	I am allowed a great deal of flexibility in my work schedule		
☐ Discoloration ☐ Loss of skin tone	I experience a great deal of change and uncertainty in my job		
☐ 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.	Other Job/Workplace Comments:		

Please list any other comments or concerns: