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Health History Questionnaire

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to my attention which is not asked on this form, please note in the "Comments" section. Thank you.

Name: ________________________________ Date: ____________________

Address: ____

City: ____________________ State: ______________ Zip Code: __________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Best to reach you: ❑ Home ❑ Work ❑ Cell ❑ Any

Preferred time: ❑ Morning ❑ Afternoon ❑ Evening ❑ Any

Email Address: ____

Age: ______ Date of Birth: ______________ Height: ________ Weight: ________

How did you hear about the office? ___________________________________

Family Physician: ______________________________ Phone #: ____________

EMERGENCY CONTACT INFORMATION:

Name: ______________ Phone #: ______________ Relationship: ______________

Main concern you would like help with: ___________________________________

____

____

When did this issue begin? Please be specific: ____________________________

____

Have you been given a diagnosis for this issue? If so, what diagnosis and by whom?: ________

____

____

Secondary issues you would like help with: ________________________________

____

What other types of treatment have you tried? ❑ Western Medicine ❑ Acupuncture

❑ Herbs ❑ Massage ❑ Physical Therapy

❑ Reiki ❑ Chiropractor ❑ Homeopathy

BETHESDA OFFICE: 5810 Wyngate Drive, Bethesda, MD 20817
WESTMINSTER OFFICE: 3922 Arters Mill Road, Westminster, MD 21158
ALEXANDRIA OFFICE: 2132 Mt. Vernon Ave, Suite 203, Alexandria, VA 22301

Past Personal Medical History of Significant Illnesses:

❏ Asthma ❏ Heart Disease ❏ Thyroid Disease ❏ High Blood Pressure

❏ Allergies ❏ Venereal Disease ❏ Diabetes ❏ Seizures

❏ Cancer ❏ Hepatitis ❏ Stroke ❏ Rheumatic Fever

❏ Other:______________________________

Hospitalizations/Surgeries (including dates): ____________________

Significant Trauma (auto accidents, falls. etc.): ____________________

Allergies (drugs, chemicals, metals, foods, etc.): ____________________

Family Medical History (check all that apply):

❏ Asthma ❏ Heart Disease ❏ Thyroid Disease ❏ High Blood Pressure

❏ Allergies ❏ Venereal Disease ❏ Diabetes ❏ Seizures

❏ Cancer ❏ Hepatitis ❏ Stroke ❏ Rheumatic Fever

❏ Other:______________________________

Medicines taken within the last two months (supplements, drugs, herbs, etc): ________________

Are there any areas of your life that you find stressful? Please describe: ________________

Do you have a regular exercise program?: ❏ Yes ❏ No

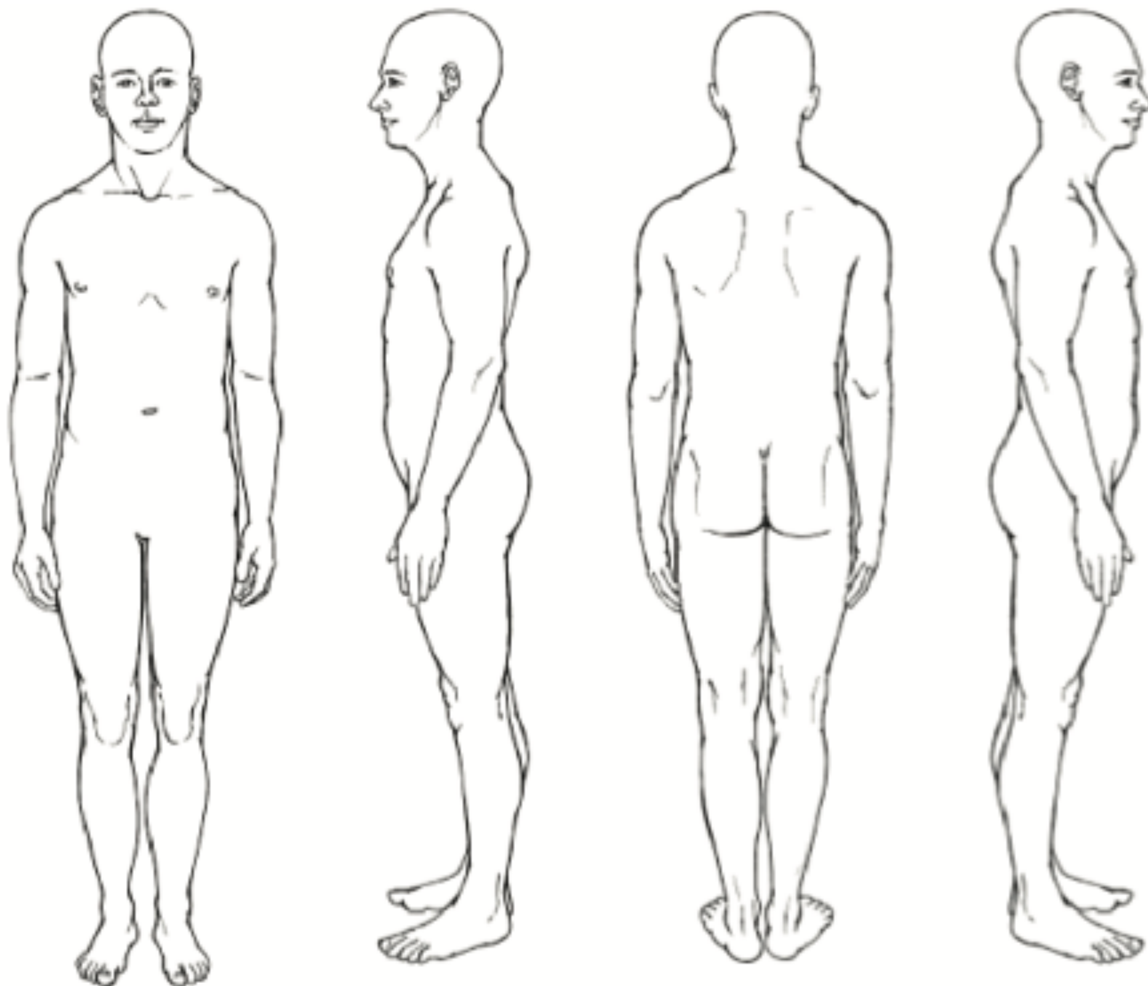
If yes, please describe: ______________________________

Do you follow any type of special diet (e.g. vegetarian, medical related or other)?: ❑ Yes ❑ No
If yes, please describe____

____

Do you smoke?: ❑ Yes ❑ No If yes, how many cigarettes or cigars per day?: __________
How many cups of caffeinated coffee, tea, or soda do you drink per week?: ________________
How many 8 oz. glasses of water do you drink per day?: ________________________________
How many alcoholic beverages do you drink per week?: ________________________________
Please describe any use of drugs for non-medical purposes: ____________________________

Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following, particularly if in the last three months:

General:

- ❑ Bleed or bruise easily
- ❑ Change in appetite
- ❑ Chills
- ❑ Cravings
- ❑ Fatigue
- ❑ Fevers
- ❑ Night sweats
- ❑ Peculiar tastes or smells
- ❑ Poor sleeping

Strong thirst for: ❑ Hot drinks ❑ Cold drinks

Sudden energy drop? ❑ Yes ❑ No

If yes, what time of day? ________________

- ❑ Sweat easily
- ❑ Weight loss
- ❑ Weight gain

Head, Eyes, Ears, Nose & Throat:

- ❑ Blurry Vision
- ❑ Clenching Jaw
- ❑ Concussions
- ❑ Earaches
- ❑ Eye strain
- ❑ Glasses
- ❑ Jaw clicks
- ❑ Night blindness
- ❑ Poor hearing
- ❑ Recurrent sore throat
- ❑ Sinus problems
- ❑ Spots in front of eyes
- ❑ Cataracts
- ❑ Color blindness
- ❑ Dizziness
- ❑ Eye pain
- ❑ Facial Pain
- ❑ Grinding teeth
- ❑ Migraines
- ❑ Nose bleeds
- ❑ Poor vision
- ❑ Ringing in ears
- ❑ Sores on lips or tongue
- ❑ Teeth problems
- ❑ Headaches, where and when? ____

Any other head or neck problems? ____

____

Skin & Hair:

- ❑ Acne
- ❑ Dandruff
- ❑ Eczema
- ❑ Itching
- ❑ Pimples
- ❑ Rashes
- ❑ Ulcerations
- ❑ Change in hair or skin texture
- ❑ Dermatitis
- ❑ Hives
- ❑ Loss of hair
- ❑ Psoriasis
- ❑ Recent moles

Any other skin or hair problems? ____

____

Respiratory:

- ❑ Asthma
- ❑ Chest tightness
- ❑ Pneumonia
- ❑ Pain with deep breath
- ❑ Bronchitis
- ❑ Cough ❑ Coughing blood
- ❑ Difficulty breathing when lying down
- ❑ Phlegm production, what color? ________

Cardiovascular:

- ❑ Blood clots
- ❑ Cold hands or feet
- ❑ Fainting
- ❑ Irregular heart beat
- ❑ Palpitations
- ❑ Phlebitis
- ❑ Swelling of hands
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Palpitations at rest
- ❑ Swelling of feet
- ❑ Varicose or spider veins

Any other heart or blood vessel problems?____

____

Gastrointestinal:

- ❑ Abdominal pain/cramps
- ❑ Bad breath
- ❑ Black stools
- ❑ Bloating/edema
- ❑ Chronic laxative use
- ❑ Constipation
- ❑ Excessive appetite
- ❑ Gas
- ❑ Hernia
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal pain
- ❑ Vomiting
- ❑ Acid reflux/GERD
- ❑ Belching
- ❑ Bleeding gums
- ❑ Blood in stools
- ❑ Colitis
- ❑ Diarrhea
- ❑ Food stagnation
- ❑ Hemorrhoids
- ❑ IBS/Crohn's disease
- ❑ Loose stools, more than 2 per day
- ❑ Poor appetite
- ❑ Slow digestion

Any other problems with stomach or intestines? ____________________________________

____

Musculoskeletal:

- ❑ Back pain: ❑ Low ❑ Middle ❑ Upper
- ❑ Carpal tunnel
- ❑ Hand/wrist pain
- ❑ Knee pain
- ❑ Muscle spasm
- ❑ Neck pain
- ❑ Sciatica
- ❑ Bursitis
- ❑ Foot/ankle pain
- ❑ Hip pain
- ❑ Muscle pain
- ❑ Muscle weakness
- ❑ Rotator cuff
- ❑ Shoulder pain
- ❑ Soreness/weakness of lower body (back, hip, knee, ankle, foot)
- ❑ Sprains/strains
- ❑ Tendonitis

Genitourinary:

- ❑ Blood in urine
- ❑ Decrease in ow
- ❑ Frequent urination
- ❑ Impotency
- ❑ Kidney stones
- ❑ Pain upon urination
- ❑ Sores on genitals
- ❑ Unable to hold urine
- ❑ Urgency to urinate

Any particular color to your urine? ____________________

Do you wake up at night to urinate? ❑ Yes ❑ No If yes, how many times a night? __________

Any other problems with your genital or urinary systems? ____________________

Neurological & Psychological:

- ❑ ADD/ADHD
- ❑ Anxiety
- ❑ Areas of numbness
- ❑ Bad temper
- ❑ Concussion
- ❑ Depression
- ❑ Dizziness
- ❑ Easily susceptible to stress
- ❑ Loss of balance
- ❑ Manic depression
- ❑ Nervousness
- ❑ Poor memory
- ❑ Poor coordination
- ❑ Seizures

Have you considered or attempted suicide? ❑ Yes ❑ No

Any other neurological or psychological problems? ____________________

Reproductive & Gynecologic:

- ❑ Breast lumps
- ❑ Clots
- ❑ Endometriosis
- ❑ Fibrocystic breast tissue
- ❑ Irregular periods
- ❑ Painful periods
- ❑ Polycystic Ovarian Disease
- ❑ Unusual character of blood
- ❑ Uterine fibroids
- ❑ Vaginal discharge
- ❑ Vaginal dryness
- ❑ Vaginal sores

Are you pregnant? ❑ Yes ❑ No

Is it possible that you may be pregnant? ❑ Yes ❑ No

# of pregnancies:__________ # live births:________ # miscarriages: __________

abortions:______________ # of premature births:____________________

Age at first menses: ________ Time between menses: __________ Duration of menses: ______

Date of last PAP: __________ Do you practice birth control? ❑ Yes ❑ No

If yes, what type? ____________________

How long? ____________________

COMMENTS

Please tell me briefly about any other concerns you would like to discuss:

____
____
____
____
____
____
____
____

Thank you