Personal History Questionnaire

Patient Information Today's Date_____

Name: _____ Date of Birth_____

Age: _____ Male❑ Female❑

Address: _____City: _____State:_____Zip:_____

Home Phone: _____ Work or Cell Phone: _____

Email Address_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Other_____

Your Occupation: _____ Your Employer_____

Referred to this office by: _____

Name of Insurance_____

Please Describe Present Major Health Concerns

1. _____

2. _____

3. _____

Our Office Policy (please initial)

1. If you need to cancel your appointment, please inform us at least 24 hours prior to your appointment to avoid a full service charge. A missed appointment will be charged at a full rate. Because we also value your time, if we must cancel with less than 24 hour notice, your next visit will be free._____
2. There is a service charge of $15.00 for every returned check from the bank._____
3. I authorize the release of any medical records/other information necessary to process a claim with my insurance._____

Medical History

(Please mark the appropriate boxes)

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Concussion
- ❑ Convulsion
- ❑ Diabetes
- ❑ Dislocated joints
- ❑ Epilepsy
- ❑ German measles
- ❑ High blood pressure
- ❑ Multiple sclerosis
- ❑ Muscular Dystrophy
- ❑ Nervousness
- ❑ Polio
- ❑ Poor circulation
- ❑ Hepatitis
- ❑ Rheumatic fever
- ❑ Rheumatism
- ❑ Scarlet fever
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Venereal Disease

Head

- ❑ Headaches
- ❑ Difficulty concentrating
- ❑ ADD/ ADHD
- ❑ Forgetful
- ❑ Head feels heavy
- ❑ Changes in hair
- ❑ Other_____ _____

Sinuses and Nose

- ❑ Sinus trouble
- ❑ Seasonal
- ❑ All year
- ❑ Runny Nose

Phlegm

- ❑ Clear
- ❑ White
- ❑ Yellow
- ❑ Green

- ❑ Other_____ _____

Eyes

- ❑ Itchy/ Watery / Dry
- ❑ Blurry
- ❑ Red eyes
- ❑ Tired
- ❑ Cataracts
- ❑ Getting weaker
- ❑ Other_____ _____

Ears

- ❑ Ringing in ears
- ❑ Ear infections
- ❑ Poor hearing
- ❑ Other_____ _____

Mouth

- ❑ Teeth problems
- ❑ Bleeding gums
- ❑ Bad breath
- ❑ Sore throat
- ❑ Jaw pain
- ❑ TMJ
- ❑ Other_____ _____

Neck

- ❑ Tension due to stress
- ❑ Pain
- ❑ Thyroid problems
- ❑ Swollen glands
- ❑ Other_____ _____

Shoulders

- ❑ Pain in joints
- ❑ Sore muscles
- ❑ Shoulder injury
- ❑ Decreased mobility
- ❑ Other_____ _____

Arms

Enter # on appropriate line

1. Upper arm
2. Elbow
3. Wrist
4. Hand
5. Fingers

____ Decreased Mobility
____ Pain
____ Numbness /tingling
____ Paralysis
____ Cold

- ❑ Other_____ _____

Chest

- ❑ Heart palpitations
- ❑ Pain in chest
- ❑ Heart skipping beats
- ❑ Heart condition
- ❑ High blood pressure
- ❑ Injury to chest
- ❑ Lung condition
- ❑ Asthma
- ❑ Shortness of breath
- ❑ Other_____ _____

Digestion

- ❑ Acid reflux/ heartburn
- ❑ Bad breath
- ❑ Food sits in stomach
- ❑ Excessive belching
- ❑ Excessive gas
- ❑ Irritable bowel syndrome
- ❑ Constipation
- ❑ Diarrhea
- ❑ Burning /Itchy Anus
- ❑ Laxative use
- ❑ Other_____ _____

Urination

- ❑ Frequent urination
- ❑ Difficulty urinating
- ❑ Bladder does not fully empty
- ❑ Up at night to urinate _____times
- ❑ Urinary tract infections
- ❑ Bladder infections
- ❑ Other_____ _____

Reproductive

Men

- ❑ Impotence
- ❑ Low desire
- ❑ Excessive desire
- ❑ Premature ejaculation
- ❑ Testicle pain
- ❑ Enlarged prostate
- ❑ Other_____ _____

Reproductive Women

- ❑ Menstruation every_____ days
- ❑ Irregular menstruation
- ❑ Heavy periods
- ❑ Light /scanty periods

Blood color

- ❑ Pink
- ❑ Bright red
- ❑ Dark red
- ❑ Purple
- ❑ Brown

- ❑ Clots
- ❑ Cramping
- ❑ Breast lumps
- ❑ Uterine fibroids
- ❑ Cysts
- ❑ Infertility
- ❑ Pregnancies_____
- ❑ Live births _____
- ❑ Fertility treatment
- ❑ Low sexual desire

Other_____ _____

Back

- ❑ Back pain
- ❑ Upper
- ❑ Middle
- ❑ Low
- ❑ Radiates into hips
- ❑ Radiates into legs
- ❑ Down back of leg
- ❑ Back surgery
- ❑ Hip pain
- ❑ Other_____ _____

Legs

- ❑ Leg pain
- ❑ Knee pain
- ❑ Knee injury
- ❑ Varicose veins
- ❑ Calf pain
- ❑ Ankle pain
- ❑ Pain in foot
  - ❑ Heel
  - ❑ Arch
  - ❑ Ball of foot
  - ❑ Toes
- ❑ Cold Feet
- ❑ Other_____ _____

Emotional Well-being

Childhood

- ❑ Childhood Stress
- ❑ School Stress
- ❑ Family Stress
- ❑ Personal relationships
- ❑ Stress of being sick
- ❑ Abuse

Adulthood

- ❑ Work related stress
- ❑ Stress of commuting
- ❑ Loss of loved one
- ❑ Relationship stress
- ❑ Change in lifestyle
- ❑ Change in vocation
- ❑ Abuse

Grade your Mental Health

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Getting Better
- ❑ Getting Worse

Have you ever been hospitalized? ❑Yes ❑No If yes, what for? _____

Surgical History:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Diet -What did you eat for breakfast, lunch and dinner yesterday?

Breakfast	Lunch	Dinner	Snacks

Was this a typical day for you? _____Yes _____No

Do you consume alcohol? _____Yes _____ No If yes, how many times per week? _____

Do you consume caffeine? _____Yes _____ No If yes, how many times per week?_____

If you take herbal supplements, please list them:

_____

_____

Please list all medication you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Are you allergic to any foods or Medication? _____Yes _____No
If yes, please list? _____

Patients Signature: _____ Date_____