

Medicap Pharmacy Health and Wellness

6635 Falls of Neuse Rd.
Raleigh, NC 27615
Phone 919.676.6161
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Medicap.Raleigh@gmail.com
Bobbie Barbrey, Rph, CCN



Monday – Friday 9AM – 7PM
Saturday 9AM – 1PM
Closed Sunday
www.MedicapRaleigh.com
Shop.MedicapRaleigh.com
Lauren Barbrey, L.Ac

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

PLEASE PRINT CLEARLY

Date:

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	AGE:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Number of Children: _____		
Email:	Phone Number:		
Address:			

What brings you to our office today?

How long have you had this condition? When did it begin?

What makes it better? What makes it worse?

If we could make a difference for you, what would be your top priority? Second?

Rate your health today on a scale of 1 – 10 with 10 being optimal. 1 2 3 4 5 6 7 8 9 10

When was the last time you felt energized, happy, and healthy?

How did you hear about Medicap Health and Wellness Services?

PERSONAL HEALTH HISTORY

Childhood illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio

List any medical problems that other doctors have diagnosed

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Surgeries or hospitalizations		
Year	Reason	Scars?

List any organs you've had removed:

What is your blood type? **A B AB O**

Dental: # of mercury amalgam fillings: _____ **# of root canals:** _____ **# of teeth pulled:** _____

What other practitioners are you working with?

List your prescribed drugs and over-the-counter drugs, such as inhalers (attach additional sheet if needed)

Name and strength of Drug	Directions for taking	How long have you been taking it?

List any supplements you are taking. (Attach additional sheet if needed)

HEALTH HABITS

Exercise	<input type="checkbox"/> Sedentary (No exercise)
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

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Stress Management	<input type="checkbox"/> Meditation			
	<input type="checkbox"/> Deep Breathing			
	<input type="checkbox"/> Yoga	Other: _____		
Diet	Are you dieting? If yes, describe: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	# of meals you eat in an average day? _____			
	Do you eat wheat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you vegetarian?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you eat dairy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you eat soy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Cola	
	# of cups/cans per day? _____			
Water	# of glasses of pure water you drink per day: _____ Or # of ounces: _____			
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, what kind? _____			
	How many drinks per week? _____			
Tobacco	Do you use tobacco? If yes, what form:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Cigarettes – pks./day: _____	<input type="checkbox"/> # of years: _____	<input type="checkbox"/> Or year quit _____	

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

DAILY HEALTH LIFE

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How many hours do you sleep per night?		

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How often do you have a bowel movement? _____ time(s) per day or every _____ days
Are your stools: watery soft well-formed hard pellet-like (circle appropriate answer)
What color are your stools? Light color of cardboard dark brown black (circle appropriate answer)
What is your current occupation? Past occupations?
What are your hobbies? Fun?
What are your biggest stressors?
Have you been exposed to pesticides?
If there was an emotional component contributing to your health condition, what would it be?

What else would you like me to know about you that may provide clues to help me improve your health?

Give this careful thought please, the simplest comments can be powerful.