# Medicap Pharmacy Health and Wellness

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

# HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.
**PLEASE PRINT CLEARLY**

*****DATE: _____**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Name** *(Last, First, M.I.):* | | | | ☐ **M** ☐ **F** | **DOB:** | **AGE:** | |
| **Marital status:** ☐ Single | ☐ Partnered | ☐ Married | ☐ Separated | ☐ Divorced | ☐ Widowed | # of Children: ____ | Ages: : _____ |
| **Email:** | | | | **Phone Number:** | | | |
| **Address:** | | | | **City:** | **State:** | **Zip Code**: | |
| **Height:** | **Weight today**: | | | **Weight 1 yr ago:** | | | |

**What brings you to our office today? Identify your top 3-5 goals**

**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: _____**

Do you know the tooth NUMBER for any root canals?

**What other practitioners are you working with? How long?**

| **List your prescribed drugs and over-the-counter drugs** (attach additional sheet if needed) | | |
|---|---|---|
| **Name and Strength of Drug** | **Directions for taking** | **How long have you been taking it?** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **SUPPLEMENTS** | | |
| **Name & Strength** | **How do you take? How long have you taken this supplement?** | |
| | | |
| | | |
| | | |
| | | |
| | | |

## HEALTH HABITS

| | |
|---|---|
| **Exercise** | ☐ Sedentary (No exercise) |
| | ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) |
| | ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) |
| | ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) |

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

## FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|---|---|---|
| **Father** | | | **Children** | ☐ M ☐ F | |
| **Mother** | | | | ☐ M ☐ F | |
| **Sibling** | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | **Grandmother** *Maternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Maternal* | | |
| | ☐ M ☐ F | | **Grandmother** *Paternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Paternal* | | |

## DAILY HEALTH LIFE

| | | |
|---|---|---|
| Is stress a major problem for you? Reason? | ☐ Yes | ☐ No |
| Do you feel depressed? Reason? | ☐ Yes | ☐ No |
| Do you have problems with eating or your appetite? | ☐ Yes | ☐ No |
| Do you have trouble sleeping? Reason? | ☐ Yes | ☐ No |
| How many hours do you sleep per night? Do you use a device that measures sleep type and time? | | |

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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?

**TOXIN EXPOSURE (Dates are very helpful)**

Have you been vaccinated against Covid? Date? Have you been boosted? Date?

Have you been exposed to pesticides or herbicides? How long?

Have you been exposed to mold or a water damaged home/building?

How old is your home?

Did you ever work on a farm? How long?

Did you ever work at a job that you might have been exposed to any toxins?

Have you been exposed to metals other than dental amalgams?

What is your current dental status-Any current or recent issues?

Do you live near a WiFi tower or overhead power lines?

What potential toxic burden are you exposed to at work?

Estimate the number of antibiotic prescriptions you have taken in your lifetime?

Were you a healthy child? If not describe

How frequently do you get sick over the last 5 years? How quick do you recover?

Did you grow up in a nurturing, emotionally stable home environment?

Did you ever have mono (Epstein Barr)?

Did you ever notice a change in your health after moving to a new building, home or work?

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. Include here or create your own document**

A timeline of your health history and events in your life are very useful to me. Attaching life events to health events can be very revealing to us both. Please give this careful thought and write this out.