HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):* ☐ **M** ☐ **F**	**DOB:**	**AGE:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ 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

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	☐ 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)				
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?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
How many hours do you sleep per night?		
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.