Integrative Health Consults, LLC

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Medical History Questionnaire

Name _____ **Date** _____

Date of Birth _____ **Age** _____ **Height** _____ft. _____ ins. **Weight** _____

Present Health Problem(s) and Description **Treatments and Results to Date**

History of Present Illness: *Describe how and when the problems began and progressed.*

How long has it been since you were well? _____
Where were you living when you became ill? _____ What were you doing? _____

Current Medications, Dose and Frequency **Response to these Medications**

Nutritional Supplements, Dose and Frequency **Response to Nutritional Supplements**

How do you feel about using herbs and supplements? _____
How do you feel about using prescription medicine? _____

Allergies or sensitivities to drugs?
____ Generally sensitive
____ Anesthetics
____ Penicillin
____ Others: _____

Allergies to Inhalants?
____ Dust
____ Grass, trees, pollen
____ Animal dander
____ Mold

Sensitivities to chemicals and smells?
____ Generally sensitive
____ Cosmetics, detergents, perfumes
____ Gas, glues, newsprint, paint, dye
____ Chlorine, formaldehyde
____ Others: _____

Name _____ Date _____

Surgeries and Hospitalizations: **Date**

_____

_____

_____

_____

_____

_____

Injuries: *(sprains, fractures, dislocations and scars and organ removal)* **Date**

_____

_____

_____

_____

Tests and Exams: Date of last completed physical: _____ Results: _____ By Whom: _____

Procedure/Test	Date	Results	Procedure/Test	Date	Results
Colonoscopy			**MEN**		
CT Scan			Prostate Exam		
DEXA/Bone Density			**WOMEN**		
EKG/Stress Test			Breast Exam		
MRI			Mammogram		
Flu Vaccine			Pap Smear		
Prosthetics			Silicon Implants		

FEMALES: Date of Last Menses ____ Number of Pregnancies ____ Number of Children ____ Pregnant? ____

Medical History: (Past and Present)

_____ Alcoholism/Addiction
_____ Allergies/Asthma
_____ Arthritis
_____ Anxiety/Depression
_____ Cancer
_____ CFIDS/Fibromyalgia
_____ Diabetes
_____ Eczema/Skin Issues
_____ Epilepsy/Seizures
_____ Glaucoma
_____ Headache/Migraine
_____ Heart Disease
_____ Hypertension
_____ Kidney Disease
_____ Liver disease
_____ Lupus
_____ Lyme Disease
_____ Psychiatric Illness
_____ Rheumatoid Arthritis
_____ Sexually Transmitted Disease
_____ Stroke
_____ Thyroid: Hypo ___ Hyper ___
_____ Viral: Herpes___ CMV ___
Polio___ Mono ___

Other Diagnosis: _____

_____

Family History: (any of which affected your parents, grandparents, siblings, children)

Relationship	***Alive/Deceased***	***Present health conditions or cause of death***
Grandparents	_____	_____
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
Children/ages	_____	_____

Check illnesses which have occurred in any of your blood relatives:

____ Addiction
____ Allergy/Asthma
____ Alzheimer's/Dementia
____ Arthritis
____ Cancer
____ Depression/Anxiety
____ Diabetes
____ Digestive Issues
____ Headaches/Migraines
____ Heart Disease
____ High Blood Pressure/Stroke
____ Lyme Disease
____ Psychiatric Illness
____ Obesity
____ Thyroid Disease

Name _____ Date_____

Dietary History: How often do you eat the following foods?

Meals per day: _____	Poultry: chicken, eggs ____ x week/month	Deli meats, bacon, ham _____x day/week/month
Snacks per day: _____	Fish and shellfish: _____x day/week/month	Sweets, candy, pastries _____x day/week/month
Water: _____ oz/day	Beans, peas, lentils: _____x day/week/month	Soft Drinks: _____x day/week/month
Prepare meals: _____ x day/week/month	Whole grains: oats, rice _____x day/week/month	Alcoholic Drinks: _____x day/week/month
Nuts and seeds: _____ x week/month	Bread, pasta, crackers _____x day/week/month	Coffee and tea: _____x day/week/month
Fruit: all kinds _____ x day/week/month	Dairy: milk, cheese: _____x day/week/month	Tobacco: _____x day/week/month
Vegetables: _____x day/week/month	Meat: beef, pork, lamb _____x day/week/month	Recreational Drugs: _____x day/week/month

1.Do you have any special dietary restrictions or preferences? _____
2.What foods do you crave if anything? _____
3.Where do you like to grocery shop? _____
4.What types of oils do you use for cooking, dressings, etc.? _____

Activity Level **Type of Activity**

_____ Sedentary (inactive) _____ by choice, or _____ due to inability or restriction.
_____ Light (light daily work and/or exercise 1-2 times a week) _____
_____ Moderate (light daily work and/or exercise 3 x a week) _____
_____ Sustained (moderate daily work and/or exercise 5 x week _____
_____ Heavy (heavy work and/or heavy exercise 6-7 x a week _____
Have you changed your exercise routine? _____

Stress/Life Management

1. I have a positive attitude about life. True_____ False _____
2. In my personal life, my stress level is: overwhelming _____ heavy _____ light _____ none _____
3. Have you changed your approach to dealing with stress? _____
4. I look forward to the future: never _____ sometimes _____ often _____ routinely _____
5. I feel at peace with myself: never __ sometimes _____ often _____ routinely _____
6. I would like to improve myself in what ways? _____
   _____
7. My relationship status is: married, divorced, life partner, separated, single. Is this recent? Yes_____ No _____
8. What expectations were met? What expectations were not met? _____
9. My relationship with my partner is: great _____ good _____ ok _____ needs work _____ poor _____ N/A _____
10. My relationship with my children is: great _____ good _____ ok _____ needs work _____ poor _____ N/A _____
11. My job situation is: great _____ good _____ ok _____ needs work _____ poor _____ N/A _____
12. In my professional life, my stress level is: overwhelming _____ heavy_____ little _____ none _____
13. Are you having any difficulties at work?_____
14. How did you feel about this survey? _____

Sleep:

1. How many hours of sleep do you get a night? _____ Do you wake feeling rested? _____
2. During the day, I am tired: never _____sometimes _____ often _____ routinely _____
3. Do you snore or have sleep apnea? _____

Name _____ Date _____

REVIEW OF SYMPTOMS

Check "PAST" or "NOW" when it applies RATE "NOW" 0-3 = 0 – Not Present 1 – Mild 2 – Moderate 3 – Severe

Symptoms	Past	Now	Comments		Symptoms	Past	New	Comments
ALLERGIES								
Seasonal Allergies					Own Dog/Cat			
Asthma					Head Congestion			
CARDIOVASCULAR SYSTEM								
High Blood Pressure					Dizzy Upon Standing			
Low Blood Pressure					Endocarditis, Heart Block			
Stroke					Heart Murmur, Valve Prolapse			
Chest Pain					Heart Palpitations			
Perspire Easily								
CONSTITUTIONAL								
Health Status : ____ Excellent ____ Good ____ Fair ____ Poor								
Migraines					Headaches			
Weight Gain					Unexplained Weight Gain			
Weight Loss					Unexplained Weight Loss			
Mild Fatigue					Extreme Fatigue, Poor Stamina			
Cold Extremities					Night Sweats			
Afternoon Drowsiness					Symptoms Come and Go			
Change in Appetite					Sensitivity to Alcohol			
Best Time of Day: **Worst Time of Day:**					Sensitivity to Chemicals			
Best Season: **Worst Season:**					Chills			
EARS, NOSE, MOUTH and THROAT								
Ear Infections					Pain in Ears			
General Hearing Loss					Sensitivity to Sounds			
Tongue Coated					Ringing, Tinnitus			
PND/Rhinitis					Plugged Ears, Decreased Hearing			
Sinusitis					Buzzing in Ears			
Sense of Smell Loss					Dental Pain			
Fillings: Mercury/Silver					Dental Problems, Unexplained			
Mouth Ulcers					Jaw Stiffness, Pain			
Bleeding Gums					Sore Throat, Hoarseness			
Bruxism (Grinding)					Phlegm, Clearing Throat			
Swallowing Problems					Runny Nose			
Jaw Pain/TMJ					Face Pain, Swelling			
Taste Loss								
Bad Breath								
E N D O C R I N E								
Hot/Heat Intolerant					Low Body Temperature			
Cold/Cold Intolerant					Hunger Headaches, Irritability			
Thyroid Disorder					Hypoglycemia, Sensitive to Food			
EYES and VISION								
Wear Eye Glasses					Blurred Vision			
Blood Shot					Floating Spots			
Burning Dry Itching					Pain in Eyes			
Cataracts					Swelling Around Eyes			
Glaucoma/Retina					Light Sensitive			
Lids Crusty					Peripheral Waves, Phantom Images			
Night Blind								
DIGESTIVE SYSTEM								
Belching, Bloating, Gas					Constipation			
Trouble Digesting Fats					Diarrhea			
Hemorrhoids, Rectal Bleeding					Pain, Stomach or Abdominal			

Name _____ Date_____

Symptoms	Past	Now	Comments		Symptoms	Past	Now	Comments
Ulcer					Cramps, Low Abdominal			
Irritable Bowel					GERD/Heartburn			
Symptoms From Food					Bowel Habit Change			
					Nausea, Upset Stomach			
GENITO - URINARY SYSTEM								
Incontinence					Frequent Bladder Infections			
Kidney Stones					Irritable Bladder			
Pain, Burning with Urination					Interstitial Cystitis			
STD's					Dark Urine			
MALE								
Impotence					Erectile Dysfunction			
Urinary Frequency					Loss of Libido			
Prostate Problems					Testicular, Genital Pain			
FEMALE								
Endometriosis, Fibroids					Menstrual Irregularity			
Cramps, Heavy Flow					Menstrual Pain			
Infertility					Pelvic Pain			
PMS					Breast Pain			
Abnormal Pap Smear					Loss of Libido			
Painful Intercourse					Health Fluctuates with Cycle			
Fibrocystic or Sore Breasts					Unexplained Breast Discharge			
Peri-Menopausal								
Are you pregnant? _____ Yes _____ No								
Number of Pregnancies _____ Full Term____ Miscarriages_____								
Menopausal: Natural _____ Surgical _____								
Hot Flashes								
Vaginal: Dryness								
Infections								
Yeast								
HEMATOLOGICAL								
Varicosities					Water Retention			
Anemia								
Bleeding Tendency								
Leg Pain with Walking								
Osteoporosis								
IMMUNOLOGICAL								
History of "Mono"					Unexplained Fevers (high or low grade)			
Autoimmune Disease					Persistent Swollen Glands			
Frequent Colds and Flu					Frequent Infections			
					Never well since infection or flu			
INTEGUMENTARY								
Acne, Eczema, Dermatitis					Crawling Sensation in Skin			
Itching, Burning, Dry					Tick Bite with Rash			
Oily					Various Rashes			
White Spots, Pigment Loss					Rash On and Off			
Yellow Tone					Frequency and Reaction to Mosquito Bites			
Nails: Brittle and Peeling					Skin Sensitivity			
Hair: Brittle, Dry					Sensitivity to Sunlight			
Male Pattern Baldness					Hair Loss, Unexplained			

Name _____ Date _____

Symptoms	Past	Now	Comments		Symptoms	Past	Now	Comments
MUSCULAR - SKELETAL								
Back Pain					Joint Pain, Swelling			
Symptoms Feel Better with Massage					Joint Stiffness, Tennis Elbow			
Intolerance to Exercise					Bone Pain			
Disc Problems					Carpal Tunnel Syndrome			
Bursitis/Tendonitis					Muscle Weakness			
Osteoporosis					Muscle Twitching, Spasms			
					Muscle Pain, Cramps			
					Sore Soles in Morning			
					Back Pain, Unexplained			
					Neck Stiffness, Pain			
NEUROLOGICAL								
Clumsy					Motion Sickness, Vertigo			
Raynaud's					Trouble Balancing, Tipsy			
Head Injury					Dizziness			
					Numbness, Tingling			
					Tremors, Unexplained Shaking			
					Light Headedness			
					Burning, Stabbing Sensations			
					Seizures, Convulsions			
					Forgetting Simple Tasks			
					Disorientation, Confusion, Getting Lost			
					Difficulty with Reading and Concentration			
					Facial Paralysis, Bell's Palsy			
					Facial Tingling, Flushing			
					Speech Difficulty			
					Memory Problems			
					Word and Name Search			
PSYCHOLOGICAL and BEHAVIORAL								
Lack of Dream Recall					Narcolepsy-Oversleeping			
Vivid Dreams					Insomnia			
Eating Disorder (List)					Unusual Depression			
Addictions (List)					Emotional, Crying Easily			
Hyperactivity/Manic					Phobias			
Attention Deficit (ADD)					Anxiety, Panic Attacks			
Obsessive/Compulsive					Mood Swings, Bipolar			
Schizophrenia/Suicidal					Seasonal Affective Disorder			
Fearful/Worrier					Hallucinations, Delusions			
Depression					Psychosis			
For Children:					Feeling as though you are losing your mind			
Behavior Problems								
Learning Difficulty								
RESPIRATORY SYSTEM								
Asthma					Shortness of Breath			
Bronchitis					Chronic Cough			
					Chest Pain, Rib Soreness			
					Air Hungry			
					Snoring, Sleep Apnea			