

Comprehensive Health History Questionnaire

Northlake Health Food
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All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:	<input type="checkbox"/> M <input type="checkbox"/> F	Age:	DOB:	/	/
Please list any health and/or fitness goals:					
			Phone:		
			Email:		

PERSONAL HEALTH HISTORY	
Illnesses (Check any that apply)	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hepatitis B or C
<input type="checkbox"/> Coronary Artery or Heart Disease	<input type="checkbox"/> Gall Stones/Gall Bladder Surgery
<input type="checkbox"/> Cardiac Arhythmia	<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Inflammatory Bowel Disease (Crohn's, UC)
<input type="checkbox"/> Heart Valve Abnormality	<input type="checkbox"/> Gastric Reflux/GERD
<input type="checkbox"/> Asthma / Bronchitis	<input type="checkbox"/> GI Ulcer (esophageal, gastric, or duodenal)
<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Frequent Urinary Tract Infections (Bladder or Kidney)
<input type="checkbox"/> Anemia	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Blood Disease / Disorder	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Deep Venous Thrombosis	<input type="checkbox"/> Cancer or Tumor, Type:
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Depression
<input type="checkbox"/> Loss of Consciousness / Head Injury	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Seizures	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Thyroid Disorder (hypothyroid, hyperthyroid, Hasimoto's or Graves)	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Diabetes Type 1 (last HBA1C =)	<input type="checkbox"/> Obsessive Compulsive Disorder (OCD)
<input type="checkbox"/> Diabetes Type 2 (last HBA1C =)	<input type="checkbox"/> Overtraining Syndrome
<input type="checkbox"/> Systemic Lupus Erythematosus (SLE)	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Alcohol/Substance Abuse
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Frequent Severe Headaches/Migraines

List any other medical conditions not specified

- 1.
- 2.
- 3.

Surgeries / Hospitalizations or Inpatient treatment

Year	Reason	Hospital

List ALL medications (include prescriptions, over-the-counter medications, vitamins, supplements, herbal remedies, etc.)

Name of Drug / Supplement	Strength (mg, etc.)	Times per Day	Start Date / Year	Prescribed By

Allergies to medications, foods, or others (latex, insect bites, environmental)

Name	Reaction

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Occupation	Occupation:	Name of employer:	
	Hours per week:	Work stress level:	
Caffeine, Alcohol, Tobacco	# of cups / cans per day? # drinks per week? Current or past tobacco use (circle) - how many years smoked when quit:		
Exercise	<input type="checkbox"/> I exercise regularly <input type="checkbox"/> I am training for an event. Event:	How long have you consistently exercised? months/years (circle)	Please check all that you participate in: <input type="checkbox"/> Run <input type="checkbox"/> Walk <input type="checkbox"/> Bike <input type="checkbox"/> Swim <input type="checkbox"/> Kayak <input type="checkbox"/> Row <input type="checkbox"/> Hike <input type="checkbox"/> Cross/Elliptical Trainer <input type="checkbox"/> Other Activity:
	# of cardio workouts/week:	Intensity (high, med, low):	Duration: - minutes/session
	# of strength workouts/week	# of sets:	# of reps:

Dietary	How would you describe your nutritional intake: # meals/day		# snacks/day	
	<input type="checkbox"/> Regular	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Low Carbohydrate	<input type="checkbox"/> High Protein
	<input type="checkbox"/> Weight Reduction	<input type="checkbox"/> Vegan	<input type="checkbox"/> Low Fat	<input type="checkbox"/> Low Sodium
	<input type="checkbox"/> Other	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Lactose Free	<input type="checkbox"/> Gluten Free

FAMILY HEALTH HISTORY

List which biologic relatives (Parents, grandparents, siblings, aunts, uncles, etc.) have the following diseases.

Alcohol/Drug Abuse		High Blood Pressure	
Asthma		Intestinal Disorder	
Bleeding Disorder		Kidney Disease	
Blood Clots		Mental Illness	
Cancer		Migraine Headaches	
Depression		Neurologic Disorder	
Diabetes		Premature Death	
Eating Disorder		Stroke	
Gynecologic Problems		Suicide Attempt	
Heart Disease/Attack		Thyroid Disease	
High Cholesterol		Other	

HEALTH MAINTENANCE

Provide date of most recent exams/procedures (if applicable):

Physical Exam:	Colon screening:	EKG:	Blood Work:
Cardiac Stress Test:	Pap (women):	Mammogram (women):	DEXA/Bone Density:
Heart Scan:	Chest X-Ray:		Tetanus Booster:

WOMEN ONLY

Age at onset of menstruation:		Date of last menstruation:	
Average period occurs every _____ days and lasts approximately _____ days.			
Heavy periods, irregularity, spotting, pain, or discharge?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of pregnancies _____ Number of live births _____			
Are you pregnant or breastfeeding?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in your urine?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Any problems with control of urination?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Any hot flashes or sweating at night?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you perform monthly self-breast examinations?			<input type="checkbox"/> Yes <input type="checkbox"/> No

MEN ONLY

Do you usually get up to urinate frequently during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased or do you have problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

REVIEW OF SYSTEMS

CHECK IF YOU CURRENTLY EXPERIENCE ANY SYMPTOMS IN THE FOLLOWING AREAS TO A SIGNIFICANT DEGREE.

General	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Fever or Chills	<input type="checkbox"/> Mental fogginess	<input type="checkbox"/> Fatigue
	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Sweats	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss
Eyes	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Eye Discharge
	<input type="checkbox"/> Vision Loss	<input type="checkbox"/> Eye Irritation/Itching	<input type="checkbox"/> Glasses	<input type="checkbox"/> Contacts
Ears, Nose and Throat	<input type="checkbox"/> Decreased Hearing	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Hoarseness
	<input type="checkbox"/> Pain Swallowing	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Dental Devices	<input type="checkbox"/> Brush & Floss Daily
Cardiovascular	<input type="checkbox"/> Chest Pain at Rest	<input type="checkbox"/> Chest Pain with Activity	<input type="checkbox"/> Peripheral Edema	<input type="checkbox"/> Palpitations
Respiratory	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Bloody Sputum
Gastrointestinal	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Bloody or Dark Stool	<input type="checkbox"/> Blood in Vomit	<input type="checkbox"/> Reflux/Heartburn
Genitourinary	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Difficulty Urinating	<input type="checkbox"/> Incontinence
	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Change in Urine Color	<input type="checkbox"/> Increased Night Urination	
Musculoskeletal	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Muscle Weakness
	<input type="checkbox"/> Muscle Twitching	<input type="checkbox"/> Muscle Aches	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Stress Fractures
Skin	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Itching	<input type="checkbox"/> Rash	<input type="checkbox"/> Suspicious Mole
	<input type="checkbox"/> Acne	<input type="checkbox"/> Unwanted Hair Growth		
Neurological	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Weakness	<input type="checkbox"/> Tremors	<input type="checkbox"/> Numbness
Psychiatric	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Self Harm Behavior	<input type="checkbox"/> Suicidal Thoughts
Endocrine	<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Increased Thirst	<input type="checkbox"/> Weight Change
Hematologic/ Lymphatic	<input type="checkbox"/> Abnormal Bruising	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Enlarged Lymph Nodes	

CERTIFICATION

The above information is true to the best of my knowledge.

X

Patient (Signature)

Date

X

Legal Guardian/Authorized Individual Signature (Required if under 18 years of age)

Date

Staff: The above health history questionnaire was reviewed by _____ (physician) on _____ (date).