Healthcare Wellness Center
Patient Health History

Name: _____ Date:_____
First Middle Last

Date of Birth:_____ Age: _____ Gender: M/F Marital Status S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? _____
   For what reason?_____

2. Please identify the health concerns that have brought you to the Wellness Center in order of importance below:

Condition	**Past Treatment**
a. _____	_____
How does this condition affect you? _____	
b. _____	_____
How does this condition affect you? _____	
c. _____	_____
How does this condition affect you? _____	
d. _____	_____
How does this condition affect you? _____	

3. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (include reaction):
   _____

   _____

4. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:
   _____

   _____

5. Do you have any reason to believe you are pregnant? Yes No
If so, how far along are you? _____

6. Do you have any infectious diseases? Yes No If yes, please identify: _____

7. Family History: Check those that apply	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

8. Height: _____ Weight: _____ Past Maximum: _____ When: _____

9. **Blood Pressure**: What is your most recent blood pressure reading? _____/_____ Taken: _____

10. **Childhood Illness** (please circle any that you have had):
Scarlet Fever Diphtheria Rheumatic Fever Mumps German Measles Chicken Pox

11. **Immunizations** (please circle any that you have had):
Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

12. **Hospitalizations and Surgeries**:

Reason	When	Reason	When
_____	_____	_____	
_____	_____	_____	
_____		_____	

13. X-Rays/CAT Scans/MRI's/Special Studies:

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

14. **Emotional** (Please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension

15. **Energy** and **Immunity** (Please circle any that you experience now and underline any that you have experienced in the past)

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

16. **Head, Eye, Ear, Nose** and **Throat**(please circle any that you experience now and underline any that 'you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throat	Teeth Grinding	TMJ/Jaw problems	Hay Fever

17. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past)

Pneumonia	Frequent Commons Colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems: _____		

18. **Cardiovascular**(please circle any that 'you experience now and underline any that 'you have experience in the past)

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

19. **Gastrointestinal** (please circle any that you experience now and underline any that you have experience in the past)

Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain
Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C
Passing Gas	Hemorrhoids	Heartburn/Acid Reflux	Abdominal Pain

20. **Genito-Urinary Tract**(please circle any that you experience now and underline any that you have experienced in the past)

Kidney Disease	Painful Urination	Frequent UTI	Frequent Urination	Heavy Flow
Kidney Stones	Impaired Urination	Blood in Urine	Frequent Urination at Night	

21. **Female Reproductive/Breasts**(please circle any that you experience now and underline any that you have experienced in the past)

Irregular Cycle	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Clotting	Bleeding Between Cycles
Menopausal Symptoms	Difficulty Conceiving	Painful Periods	

22. Menstrual/Birthing History

1. Age of first menses:_____	4. Birth Control Type:_____	7. # of Abortions: _____
2. # of days of Menses:_____	5. # of Pregnancies: _____	8. # of live births: _____
3. Length of cycle: _____	6. # of Miscarriages: _____	

23. **Male Reproductive**(please circle any that you experience now and underline any that you have experienced in the past)

Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

24. **Musculoskeletal**(please circle any that you experience now and underline any that you have experienced in the past)

Neck/Shoulder pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain
Low Back pain Leg Pain Joint Pain (if so, where?)_____

25. **Neurologic**(please circle any that you experience now and underline any that you have experienced in the past)

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

26. **Endocrine**(please circle any that you experience now and underline any that 'you have experienced in the past)

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

27. Other(please circle any that you experience now and underline any that you have experienced in the past)

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____
_____

28. Lifestyle

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: _____Employer_____ hours/week:_____

Do you enjoy work? Y N Why/Why not? _____

g. **Nicotine/Alcohol/Caffeine** Use: _____

h. Have you experienced any major traumas? Y N Explain: _____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Television habits: _____ Reading habits: _____

k. Interests and hobbies: _____

_____