HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Address:		**Phone**:
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	**Date of last physical exam:**
Have you been to a Naturopathic Physician before? ☐ Yes ☐ No		
How did you hear about us? ☐ Online search ☐ Newspaper ☐ Radio ☐ Family/Friend referral If online search please list what you typed in the search bar(keyword):		
Who is your family doctor?		**Doctor/s address and/or phone number:**
Your MSP Number:		**Today's Date:**

PERSONAL HEALTH HISTORY		
Childhood illness: Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

What is the purpose of your visit today?	**List any medical problems that other doctors have diagnosed.**

Surgeries	Reason	Hospital
Year		

Other hospitalizations	Reason	Hospital
Year		

List your prescribed drugs and over-the-counter drugs, such as oral medications and inhalers		
Name of Drug	Strength	Frequency Taken
List your supplements and herbal medication. Please list the name, dosage you take, how long you've been taking it.		
Name	Dosage	How long have you been taking it
Allergies to medications		
Name the Drug or Supplement	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

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Energy: Please circle (0 is completely exhausted and 10 is excellent energy)	0	1	2	3	4	5	6	7	8	9	10
Sleep: Do you have any difficulty *falling asleep or staying asleep*? ☐ Yes ☐ No How many hours do you sleep?											

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)				
Diet	DIGESTION: Any problems with constipation, diarrhea, gas, bloating?			☐ Yes	☐ No
	Are you dieting?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	What is your typical breakfast?				
	What is your typical lunch?				
	What is your typical dinner?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	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*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Are you easily angered?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you feel sad and/or cry frequently?	☐ Yes	☐ No
Do you worry?	☐ Yes	☐ No

ENVIRONMENTAL MEDICINE

Have you ever lived in an old house or apartment?	☐ Yes	☐ No
Have you lived or worked on a farm or in agriculture?	☐ Yes	☐ No
Have you ever drank from well water?	☐ Yes	☐ No

Do ever had any "silver" fillings/amalgams?	☐ Yes ☐ No
If yes, how many?	
Are you sensitive to perfume or cigarette smoke?	☐ Yes ☐ No
Work History	
List all places you have worked (please include industrial and chemical workplace):	
AND circle any of the following jobs you've had (painters, dry cleaners, construction workers, printers, beauticians, auto mechanics, truck driver.)	
Do suspect that you have been exposed to any heavy metals, like lead arsenic, mercury, or cadmium?	

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days If none, then how long have you been menopausal?		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a hysterectomy?	☐ Yes	☐ No
Have you had your ovaries removed?		
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Have you had your testosterone level tested?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a *significant degree* and *briefly* explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	