|  |  |  |
| --- | --- | --- |
|  | Original Date: | date |
| HEALTH HISTORY QUESTIONNAIRE |
| All questions contained in this questionnaire are strictly confidential  |
| Name (**Last, First):** . | **Sex:** . | DOB: . | **Age:**. |
| Marital status: . Single |  . Partnered |  . Married |  . Separated |  . Divorced |  . Widowed *(year)*  | . |
| **Number of children:** . | Blood Type: . |
| Who do you live with? . | Any house pets? *(Specify)* . |
| Referred by: . | Date of last physical exam: . |
| Address*: (number, street)* . | City: . |
| Province, Country: . | Home phone: | . |
| Occupation: . | Office phone: | . |
| E-mail: . | Cell phone: | . |
| Emergency contact: *(name/relation)* . | Emergency Phone: | . |
| Name of General practitioner: . | GP phone: | . |
| Other healthcare providers: . |
| Do you have, or had in the past, any mercury fillings? . |
| **Have you or your family experienced a major tragic change or loss, what?** ***(death, divorce, accident, etc. If yes, describe event(s) and date)*** | . |
| **Do you suffer from any allergies? Medications, Foods, Environmental…, Complete the table below** |
| **Name of allergen: *medication, food, environmental, …*** | **Since**  | **Reaction you had** |
| . | . | . |
| . | . | . |
| . | . | . |
| **List by order of priority, top 3 health concerns you would like to address** *(specify details: date of onset, severity, previous treatments and outcome)* |
|  | Condition | **Since**  | **Treatment undergone & Outcome *(none, mild, moderate, excellent)*** |
| **1.** | . | . | . |
| **2.** | . | . | . |
| **3.**  | . | . | . |
|  |
| PERSONAL HEALTH HISTORY |
|  |
| Childhood illness:*Mark a ‘X’ if you had illness* |  . **Measles**  . **Mumps**  . **Rubella**  . **Chickenpox**  . **Rheumatic Fever**  . **Polio** |
| Immunizations *Indicate with an ‘X’ if* *you had this vaccine* |  . | **Tetanus, Diphtheria, Pertussis, Polio**  |  . | **Pneumonia** |  . | **Tetanus** |
|  . | **MMR Measles, Mumps, Rubella** |  . | **Chickenpox** |  . | **Meningococcal** |
|  . | **Influenza** |  . | **Hepatitis A** |  . | **Zoster** |
|  . | **HPV** |  . | **Hepatitis B** |  .  | **Other** |
| List any medical problems that have been diagnosed by a medical doctor  |
|  | **Date** | **Condition, treatment(s) undergone, outcome** |
| **1** | . | . |
| **2** | . | . |
| **3** | . | . |
| **4** | . | . |
| **HEALTH HISTORY QUESTIONNAIRE – Page 2**All questions contained in this questionnaire are strictly confidential  |
| **MEDICAL HISTORY** |
| **Year** | **Condition** | **Severity**(mild, moderate, severe) | **Treatment***(medicine or supplement, mg/day)* | **outcome**(none, mild, moderate, excellent) |
| . | **Allergies** | . | . | . |
| . | **Anemia** | . | . | . |
| . | **Arthritis, rheumatism, osteoarthritis** | . | . | . |
| . | **Thyroid problem** | . | . | . |
| . | **Cancer/Leukemia** | . | . | . |
| . | **Cardiovascular disease** | . | . | . |
| . | **Elevated cholesterol** | . | . | . |
| . | **Elevated triglycerides** | . | . | . |
| . | **Hypertension** | . | . | . |
| . | **Stroke** | . | . | . |
| . | **Lung disease (emphysema, bronchitis, pneumonia)** | . | . | . |
| . | **Diabetes, type I/Type II, hyperglycemia** | . | . | . |
| . | **Epilepsy/convulsions** | . | . | . |
| . | **Osteoporosis** | . | . | . |
| . | **Gout** | . | . | . |
| . | **Hepatitis, Jaundice** | . | . | . |
| . | **Digestive disorders (Crohn’s, IBS)** | . | . | . |
| . | **Pelvic inflammatory disease** | . | . | . |
| . | **Prostatitis** | . | . | . |
| . | **Kidney problems (stones, UTI’s)** | . | . | . |
| . | **Sexually transmitted disease, HIV** | . | . | . |
| . | **Skin problems** | . | . | . |
| . | **Mental/Mood disorders** | . | . | . |
| . | **Chemical dependence (drugs, alcohol)** | . | . | . |
| . | **Thyroid problems** | . | . | . |
| Surgeries |
| **Year** | **Reason** | **Hospital/Outcome** |
| . | . | . |
| . | . | . |
| . | . | . |
| . | . | . |
| . | . | . |
| Other hospitalizations |
| **Year** | **Reason** | **Hospital/Outcome** |
| . | . | . |
| . | . | . |
| . | . | . |
| . | . | . |
| **HEALTH HISTORY QUESTIONNAIRE – Page 3**All questions contained in this questionnaire are strictly confidential  |
| Have you ever had a blood transfusion? | . |

|  |
| --- |
| **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** |
| **Name the Drug or Supplement*****(compound and brand name)*** | **Strength & Frequency*****(ex. mg/pill & number of pills/day)*** | **Reason for taking drug** | **Outcome**  |
| . | . | . | . |
| . | . | . | . |
| . | . | . | . |
| . | . | . | . |
| . | . | . | . |
| . | . | . | . |
| . | . | . | . |
| . | . | . | . |
| . | . | . | . |
| . | . | . | . |
| **FAMILY HEALTH HISTORY** |
|  | **AGE** | **Significant health problems or age deceased** | **Children** | **Sex** | **AGE** | **Significant health problems or age deceased** |
| **Father** | . | . | ***Male = M******Female = F*** | . | . | . |
| **Mother** | . | . | . | . | . |
| **Siblings** | . | . | . |  | . | . | . |
| ***Male = M******Female = F*** | . | . | . |  | . | . | . |
| . | . | . | **Grandmother *Maternal*** | . | . |
|  | . | . | . | **Grandfather *Maternal*** | . | . |
|  | . | . | . | **Grandmother *Paternal*** | . | . |
|  | . | . | . | **Grandfather *Paternal*** | . | . |
|   |
| HEALTH HABITS AND PERSONAL SAFETY |
|  |
| Medications | **Approximately how many times have you taken antibiotics in your lifetime?** . | **In past 2 years?** . |
| **Approximately how many times have you taken anti-inflammatories in your lifetime?** . | **In past 2 years?** . |
| Exercise | **Do you exercise regularly?** | . |
| **Regular Mild exercise, what and how often? *(i.e. climb stairs, walk 3 blocks, golf)*** . |
| **Regular vigorous exercise, what and how often? *(i.e. 4x/week for 30 minutes)*** . |
| Diet | **Are you dieting or on a special diet? *(Weight loss, athletic, medical, etc.)*** |  | . |
| **Do you have any dietary restrictions (religious, vegetarian, etc.?)** |  | . |
| **Number of glasses of water you drink in an average day?** . |
| **Rank salt intake:** . **Rank sugar intake:** . **Rank fat intake:** . |
| Caffeine | **Caffeine:** . **Coffee:** . **Tea:** . **Cola, energy drinks:** . **# of cups/cans you consume per day:** . |
| Tobacco | **Do you use tobacco?** | . |
| **Cigarettes – pks./day:** . **Chew - #/day:** . **Pipe - #/day:** . **Cigars - #/day:** . |
| **Number of years:** . | **Or year quit:** . |
| **HEALTH HISTORY QUESTIONNAIRE – Page 4**All questions contained in this questionnaire are strictly confidential  |
|  | **Answer Yes or No and give details where required** |
| Alcohol | **Do you drink alcohol?** | . |
| **If yes, what kind and how many drinks per week/per day?** . |
| **Are you prone to “binge” drinking or have you ever experienced blackouts?** | . |
| **Any current or past alcohol addiction problems?** | . |
| **If yes, when, duration, treatments received, result:** . |
| Drugs | **Do you currently use recreational or street drugs?** | . |
| **If yes, since when, which drugs, have you tried to stop?** . |
|  | **Have you ever used recreation or street drugs in the past**  | . |
|  | **If yes, when, what, treatments to stop?** . |
| Sex | **Are you sexually active?** | . |
| **If yes, are you trying for a pregnancy?** | . |
| **If not trying for a pregnancy list contraceptive or barrier method used:** . |
| **Any discomfort with intercourse?** | . |
| **Stress** | **Is stress a major problem for you?** | . |
|  | **Is your work a source of major stress for you?** | . |
| **Is your personal life a source of major stress for you?** | . |
| **Do you feel depressed?** | . |
| **Do you panic when stressed?** | . |
| **Do you cry frequently?** | . |
| **Psychotherapy** | **Are you currently undergoing psychotherapy?** | . |
|  | **If yes, specify reason, date, treatment, outcome:** . |
| **Have you ever undergone psychotherapy in the past?** | . |
| **If yes, specify reason, date, treatment, outcome:** . |
| **Sleep** | **Do you have trouble falling asleep?** | . |
|  | **Is your sleep interrupted? If yes, what time(s)?** | . |
| **Have you been diagnosed with sleep apnea?** | . |
|  | **Do you use sleeping often? If yes, which ones and how many times per week:** . | . |
|  | **What time do you go to sleep?** . |  |
| **What time do you wake up?** |  |
| Personal Safety | **Do you live alone?** | . |
| **Do you have frequent falls?** | . |
| **Do you have vision or hearing loss?** | . |
|  | **Do you drive?** | . |
|  | **If no, for medical or other reason?** . |
| **Leisure & Social** | **Do you have any hobbies? *(i.e. music, cooking, painting…)*** . |
|  | **How do you like to spend your free time?*(alone reading, movies, with friends, etc.)*** . |
|  | **o you do any community volunteer work? If yes, what?** . | . |
|  | **Do need to be busy with plans, outings and activities all the time?** . | . |
|  | **Do you prefer to be alone most of the time?** . | . |
|  | **Do you like to be with friends and people all the time?** . | . |
| **HEALTH HISTORY QUESTIONNAIRE – Page 5**All questions contained in this questionnaire are strictly confidential |
| **WOMEN ONLY** |
| **Answer Yes or No with an ‘’X’’ in the appropriate box and give details where required** | **Yes/No** |
| **Age at onset of menstruation:** . **Date of last menstrual period:** . **Age at menopause:** . |
| **Length of menstrual cycle?** . |  **Number of days you menstruate:** |  |
| **Is the cycle regular?**  | . |
| **Do you have heavy periods?** | . |
| **Do you have bleeding between periods?** | . |
| **Do you have any pain/cramps?** | . |
| **Do you have premenstrual symptoms? tension, pain, bloating, irritability, or other symptoms at or around time of period** | . |
| **Do you any abnormal vaginal discharge?** | . |
| **Any hot flashes or sweating at night?** | . |
| **Any loss of or poor libido?** | . |
| **Any facial hair or increase in facial hair?** | . |
| **Number of pregnancies:** . |  **Number of live births:** . |  **Number of abortions:** . |
| **Are you pregnant or breastfeeding?** | . |
| **Have you ever used birth control pills? If yes, for how long?** . |  |
| **Have you ever used hormone replacement therapy? If yes, for how long?** . |  |
| **Have you had a D&C, hysterectomy, or Cesarean? If yes, specify:** . |  |
| **Do you perform regular breast self-exams?** | . |
| **Experienced any recent breast tenderness, lumps, or nipple discharge?** | . |
| **Any urinary tract, bladder, or kidney infections within the last year?** | . |
| **Any history of kidney or bladder stones (calculi)?** | . |
| **Any blood in your urine?** | . |
| **Any problems with control of urination (incontinence)?** | . |
| **Do you have any pain during sexual activity?** | . |
| **Date of last pap and rectal exam?. Any abnormal findings, explain? .** | . |
|  |
| **MEN ONLY** |
| **Do you usually get up to urinate during the night? If yes, number of times:**  |  | . |
| **Do you feel pain or burning with urination?** | . |
| **Any blood in your urine?** | . |
| **Do you feel burning discharge from penis or do you have any genital sores?** | . |
| **Has the force of your urination decreased?** | . |
| **Do you have any problems emptying your bladder completely?** | . |
| **Have you had any kidney, bladder, or prostate infections within the last 12 months?** | . |
| **Any history of kidney or bladder stones (calculi)?** | . |
| **Any difficulty with erection or ejaculation?** | . |
| **Any testicle pain, swelling or mass/ hernia?** | . |
| **Do you have an enlarged prostate?** | . |
| **Any loss of or poor libido?** | . |
| **Date of last prostate and rectal exam:**. **Any abnormal findings, explain?** .  | . |
| **HEALTH HISTORY QUESTIONNAIRE – Page 6**All questions contained in this questionnaire are strictly confidentialAll questions contained in this questionnaire are strictly confidential |
| **OTHER PROBLEMS** |
| For each symptom, that you have, indicate level of discomfort: 1 = rarely/benign, 2 = often/moderate, 3 = frequently/severe |

|  |  |  |
| --- | --- | --- |
| **Gastrointestinal/Nutritional** | **Lungs/Heart/Respiration/Circulation** | **Nervous/Skin/Energy/muscular/Other** |
| **Frequent hunger, need to nibble** | . | **Asthma** | . | **Anxiety, nervousness** | . |
| **Loss of appetite** | . | **Bronchitis, chronic** | . | **Depression** | . |
| **Sugar cravings** | . | **Tonsillitis, chronic**  | . | **Panic Attack** | . |
| **Salt cravings** | . | **Sinusitis, chronic** | . | **Difficulty concentrating** | . |
| **Slow digestion, heaviness in stomach** | . | **Chronic cough** | . | **Poor memory** | . |
| **Acid reflux** | . | **Hoarseness in throat**  | . | **Hypersensitivity to noise** | . |
| **Headaches after eating fatty foods** | . | **Mucus, post-nasal drip** | . | **Restless legs syndrome** | . |
| **Frequent nausea** | . | **Nasal congestion, chronic** | . | **Excessive irritability** | . |
| **Tired after eating** | . | **Frequent colds** | . | **Insomnia** | . |
| **Abdominal cramps** | . | **Angina, chest pain** | . | **Vivid dreams** | . |
| **Intestinal gas, flatulence, burping** | . | **Chest tightening, worse with exercise** | . | **Acne** | . |
| **Weakness/dizziness when hungry** | . | **Sighing, need to take deep breath** | . | **Psoriasis** | . |
| **Chronic constipation** | . | **Elevated serum cholesterol** | . | **Eczema** | . |
| **Chronic diarrhea** | . | **Elevated serum triglycerides** | . | **Dry, scaly skin** | . |
| **Alternating constipation/diarrhea** | . | **Hypertension** | . | **Chicken skin on arms** | . |
| **Hemorrhoids** | . | **Hypotension** | . | **Dry mouth** | . |
| **Anal itching or burning** | . | **palpitations** | . | **Dry eyes** | . |
| **Mouth ulcers** | . | **Arrhythmia, irregular heart beat** | . | **Itchy eyes** | . |
| **Bleeding gums** | . | **Frequent cold hands and/or feet** | . | **Dandruff** | . |
| **Bad breath** | . | **Swelling of ankles** | . | **Wax buildup in ears** | . |
| **Tongue fissures** | . | **Frequent numbness hands/feet** | . | **Itchy ears** | . |
| **Cracks in corners of mouth** | . | **Slow circulation** | . | **Tinnitus (noise in ears)** | . |
| **Difficulty losing weight** | . | **Frequent nose bleeds** | . | **Slow healing** | . |
| **Difficulty gaining weight** | . | **Varicose veins** | . | **Thinning hair, hair loss** | . |
| **Nails soft/brittle** | . | **Easy bruising** | . | **Loss of hair on outer legs** | . |
| **Nails have white spots** | . | **Excessive bleeding if injured** | . | **Eyebrow thinning** | . |
| **Nails have vertical ridges** | . | **Hypersensitivity to light** | . | **Feel cold easily, can’t bear the cold** | . |
| **Shaking hands** | . | **Frequent migraines** | . | **Feel hot easily, can’t bear the heat** | . |
| **Frequent muscle spasms and tics** | . | **Any vision changes with headaches** | . | **Joint stiffness upon waking** | . |
| **Nocturnal leg cramps** | . | **Vertigo/dizziness** | . | **Swollen joints** | . |
| **Daytime muscle cramps** | . | **Rosacea**  | . | **Back/neck pain** | . |

|  |
| --- |
| **HEALTH HISTORY QUESTIONNAIRE – Page 7**All questions contained in this questionnaire are strictly confidentialAll questions contained in this questionnaire are strictly confidential |
| **EATING HABITS** |
| **How often do you eat fast food per week?** . |
| **How often do you eat desert or sweets per week?** . |
| **How often do you eat chips or other salty snacks per week?** . |
| **How many meals do you eat per day?** . |
| **How many snacks do you eat per day, at what time(s)?** . |
| **Do you eat at regular times each day most of the time?** . |
| **Describe a typical breakfast:** . |
| **Describe a typical lunch:** . |
| **Describe a typical dinner:** . |
| **Describe a typical snack:** . |

|  |
| --- |
| **PLEASE ADD ANY FURTHER INFORMATION THAT YOU DEEM RELEVANT** |
| . |
| . |
| . |
| . |
| . |
| . |
| . |
| . |
| . |
| . |
| . |
| . |

|  |
| --- |
| **IMPORTANT INFORMATION & DISCLAIMER** |
| *Please read the following terms and conditions and check the ‘’I agree’’ box at the bottom with an ‘’X’’ to indicate that you agree* |
| **The information and advice provided may not be construed as medical advice nor is it intended to diagnose, treat, suggest a course of**  |
| **treatment, cure or prevent any disease or condition. It is neither intended nor implied to be a substitute for professional medical**  |
| **advice. Any users should always seek the advice of their physician prior to beginning any treatment and never disregard professional**  |
| **medical advice or delay in seeking such advice because of information obtained from myself or from my website.**  |
|  |
| **I acknowledge that I understand that all advice, food plans and suggested natural supplements are tools to improve my physiology**  |
| **and/or body biochemistry. They are not intended to heal any type of disease and no diagnosis will be established. I also acknowledge**  |
| **that I am fully responsible for all the information that I have given to the naturopath regarding my health.**  |
| **I certify that I am over 18 years of age and that I have read, understood and agreed to the terms and conditions above** | **I Agree .** |
|  |