



## **Health History Questionnaire**

Have you had any of the following conditions? Please check, explain and/or date if needed.

### **Ears Eyes Nose & Throat**

Dry eyes \_\_\_\_\_  
Conjunctivitis \_\_\_\_\_  
Hearing loss \_\_\_\_\_  
Ear infections \_\_\_\_\_  
Sinus issues \_\_\_\_\_  
Strep throat \_\_\_\_\_  
Tonsillitis \_\_\_\_\_  
Tonsillectomy \_\_\_\_\_  
Contacts \_\_\_\_\_  
Glasses \_\_\_\_\_  
Other \_\_\_\_\_

### **Skin**

Rashes \_\_\_\_\_  
Herpes \_\_\_\_\_  
Psoriasis \_\_\_\_\_  
Eczema \_\_\_\_\_  
Skin Cancer \_\_\_\_\_  
Piercing \_\_\_\_\_ Location \_\_\_\_\_  
Tattoos \_\_\_\_\_ Location \_\_\_\_\_  
Other \_\_\_\_\_

### **Respiratory**

Asthma \_\_\_\_\_  
Pneumonia \_\_\_\_\_  
Tuberculosis \_\_\_\_\_  
Bleeding disorder \_\_\_\_\_  
Anemia \_\_\_\_\_  
Other \_\_\_\_\_

### **Cardio**

Heart Murmur \_\_\_\_\_  
High Blood Pressure \_\_\_\_\_  
Palpitations \_\_\_\_\_  
High Cholesterol \_\_\_\_\_  
Rheumatic fever \_\_\_\_\_  
Other \_\_\_\_\_

### **Gastroenterology**

Stomach problems \_\_\_\_\_  
Ulcers \_\_\_\_\_  
Celiac disease \_\_\_\_\_  
Chronic Heartburn \_\_\_\_\_  
Hepatitis \_\_\_\_\_

### **Skeletal**

Arthritis \_\_\_\_\_  
Back problems \_\_\_\_\_  
Serious disability \_\_\_\_\_  
Broken bones \_\_\_\_\_  
Location \_\_\_\_\_  
Chronic Bone disease \_\_\_\_\_  
Joint problems \_\_\_\_\_  
Muscle problems \_\_\_\_\_  
Other \_\_\_\_\_

### **Mental Health**

Anxiety \_\_\_\_\_  
Depression \_\_\_\_\_  
Bulimia \_\_\_\_\_  
Anorexia \_\_\_\_\_  
Cutting \_\_\_\_\_  
Suicidal History \_\_\_\_\_

### **Neurology**

Seizures \_\_\_\_\_  
Epilepsy \_\_\_\_\_  
Narcolepsy \_\_\_\_\_  
Fainting \_\_\_\_\_  
ADD/ADHD \_\_\_\_\_  
Autism \_\_\_\_\_  
Aspergers \_\_\_\_\_  
Dyslexia \_\_\_\_\_  
Tourettes \_\_\_\_\_  
Learning Disability \_\_\_\_\_  
Headaches \_\_\_\_\_  
Migraines \_\_\_\_\_  
Sleep Disorder \_\_\_\_\_  
Other \_\_\_\_\_

### **Endocrine**

Thyroid disease \_\_\_\_\_  
Diabetes \_\_\_\_\_  
PCOS \_\_\_\_\_

### **Social History**

Alcohol abuse \_\_\_\_\_  
How much do you  
drink? \_\_\_\_\_ how often \_\_\_\_\_  
Tobacco \_\_\_\_\_ pks per day \_\_\_\_\_  
How long \_\_\_\_\_  
Dip \_\_\_\_\_

### **ALLERGIES:**

Please list your allergies:  
Meds, Food, Environmental

### **Medications and Dosing:**

Include Birth Control, Vitamins,  
Herbal Therapy

### **Surgical History**

Have you had any surgeries in  
your life time? \_\_\_\_\_

List what type and the year it  
was done.

### **Do you or your blood relatives have any of the following conditions?**

Alcoholism \_\_\_\_\_  
Arthritis \_\_\_\_\_  
Chronic Back Problems \_\_\_\_\_  
Heart disease \_\_\_\_\_  
Cancer \_\_\_\_\_  
Celiac \_\_\_\_\_  
Chron's disease \_\_\_\_\_  
COPD \_\_\_\_\_  
Colitis \_\_\_\_\_  
Cystic fibrosis \_\_\_\_\_  
Depression \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Drug dependency \_\_\_\_\_  
Hypertension \_\_\_\_\_  
Hyperlipidemia \_\_\_\_\_  
MS \_\_\_\_\_  
Pulmonary emboli \_\_\_\_\_  
PVD \_\_\_\_\_  
Rheumatoid arthritis \_\_\_\_\_  
Other \_\_\_\_\_

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