



# Personal History Questionnaire

## Patient Information

Today's Date \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Age: \_\_\_\_\_ Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work or Cell Phone: \_\_\_\_\_

Email Address \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Separated  Other \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Your Employer: \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

Name of Insurance \_\_\_\_\_

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## Please Describe Present Major Health Concerns

Please Rate Your Symptoms (1-10 with 1 being least serious)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list any Physicians you are currently seeing and the reason for their care:

\_\_\_\_\_

\_\_\_\_\_

# Medical History

(Please mark the appropriate boxes)

- AIDS/HIV
- Anemia
- Arthritis
- Asthma
- Cancer
- Concussion
- Convulsions
- Diabetes

- Dislocated joints
- Epilepsy
- German measles
- High blood pressure
- Multiple sclerosis
- Muscular Dystrophy
- Nervousness
- Polio

- Poor circulation
- Hepatitis
- Rheumatic fever
- Rheumatism
- Scarlet fever
- Stroke
- Tuberculosis
- Venereal Disease

## Head

- Headaches
- Difficulty concentrating
- ADD/ ADHD
- Forgetful
- Head feels heavy
- Changes in hair
- Other \_\_\_\_\_

## Sinuses and Nose

- Sinus trouble
- Seasonal
- All year
- Runny Nose
- Phlegm*
  - Clear
  - White
  - Yellow
  - Green
- Other \_\_\_\_\_

## Eyes

- Itchy
- Watery
- Dry
- Tired
- Cataracts
- Getting weaker
- Other \_\_\_\_\_

## Ears

- Ringing in ears
- Ear infections
- Poor hearing
- Other \_\_\_\_\_

## Mouth

- Teeth problems
- Bleeding gums
- Bad breath
- Sore throat
- Jaw pain
- TMJ
- Other \_\_\_\_\_

## Neck

- Tension due to stress
- Pain
- Thyroid problems
- Swollen glands
- Other \_\_\_\_\_

## Shoulders

- Pain in joints
- Sore muscles
- Shoulder injury
- Decreased mobility
- Other \_\_\_\_\_

## Arms

Enter # on appropriate line

1. Upper arm
2. Elbow
3. Wrist
4. Hand
5. Fingers

- \_\_\_\_ Decreased Mobility
- \_\_\_\_ Pain
- \_\_\_\_ Numbness /tingling
- \_\_\_\_ Paralysis
- \_\_\_\_ Cold
- Other \_\_\_\_\_

## Chest

- Heart palpitations
- Pain in chest
- Heart skipping beats
- Heart condition
- High blood pressure
- Injury to chest
- Lung condition
- Asthma
- Shortness of breath
- Other \_\_\_\_\_

## Digestion

- Acid reflux
- Heartburn
- Food sits in stomach
- Excessive belching
- Excessive gas
- Irritable bowel syndrome
- Constipation
- Diarrhea
- Pain
- Other \_\_\_\_\_

## Urination

- Frequent urination
- Difficulty urinating
- Bladder does not fully empty
- Up at night to urinate \_\_\_\_\_ times
- Urinary tract infections
- Bladder infections
- Other \_\_\_\_\_

## Reproductive Men

- Impotence
- Low desire
- Excessive desire
- Premature ejaculation
- Testicle pain
- Enlarged prostate
- Other \_\_\_\_\_

## Reproductive Women

- Menstruation every \_\_\_\_\_ days
- Irregular menstruation
- Heavy periods
- Light /scanty periods
- Blood color*
  - Pink
  - Bright red
  - Dark red
  - Purple
  - Brown

- Clots
- Cramping
- Breast fibroids
- Uterine fibroids
- Cysts
- Infertility
- Pregnancies \_\_\_\_\_
- Live births \_\_\_\_\_
- Fertility treatment
- Low sexual desire
- Other \_\_\_\_\_

<p><b><u>Back</u></b></p> <input type="checkbox"/> Back pain <input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Low <input type="checkbox"/> Radiates into hips <input type="checkbox"/> Radiates into legs <input type="checkbox"/> Down back of leg <input type="checkbox"/> Back surgery <input type="checkbox"/> Hip pain <input type="checkbox"/> Other _____ _____	<p><b><u>Legs</u></b></p> <input type="checkbox"/> Leg pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Knee injury <input type="checkbox"/> Varicose veins <input type="checkbox"/> Calf pain <input type="checkbox"/> Ankle pain <input type="checkbox"/> Pain in foot <input type="checkbox"/> Heel <input type="checkbox"/> Arch <input type="checkbox"/> Ball of foot <input type="checkbox"/> Toes <input type="checkbox"/> Cold Feet <input type="checkbox"/> Other _____ _____	<p><b><u>Emotional Well-being</u></b></p> <p><b><u>Childhood</u></b></p> <input type="checkbox"/> Childhood Stress <input type="checkbox"/> School Stress <input type="checkbox"/> Family Stress <input type="checkbox"/> Personal relationships <input type="checkbox"/> Stress of being sick <input type="checkbox"/> Abuse <p><b><u>Adulthood</u></b></p> <input type="checkbox"/> Work related stress <input type="checkbox"/> Stress of commuting <input type="checkbox"/> Loss of loved one <input type="checkbox"/> Relationship stress <input type="checkbox"/> Change in lifestyle <input type="checkbox"/> Change in vocation <input type="checkbox"/> Abuse	<p><b><u>Grade your Mental Health</u></b></p> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Getting Better <input type="checkbox"/> Getting Worse
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Have you ever been hospitalized?  Yes  No If yes, what for? \_\_\_\_\_

Surgical History:

- |          |             |
|----------|-------------|
| 1. _____ | Date: _____ |
| 2. _____ | Date: _____ |
| 3. _____ | Date: _____ |

**Diet** -What did you eat for breakfast, lunch and dinner yesterday?

Breakfast	Lunch	Dinner	Snacks

Was this a typical day for you? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you consume alcohol? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, how many times per week? \_\_\_\_\_

Do you consume caffeine? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, how many times per week? \_\_\_\_\_

If you take herbal supplements, please list them:

\_\_\_\_\_

\_\_\_\_\_

Please list all medication you are currently taking:

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Are you allergic to any foods or Medication? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list? \_\_\_\_\_

**Patients Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_