Golden Naturopathic Clinic
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HEALTH HISTORY QUESTIONNAIRE

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

Name:		Phone:
Previous referring doctor:	☐ M ☐ F Age:	DOB:
Other health care providers:		Date of last physical exam:
What brings you into the office today?		
What are your expectations?		
Prescription (Rx) meds?	Supplements?	
Past surgeries?	Medication Allergies?	

PERSONAL HEALTH HISTORY

Childhood illness:

Immunizations: ☐ Tetanus ☐ Hepatitis ☐ Influenza ☐ Pneumonia ☐ Chickenpox ☐ MMR

List any medical problems that other doctors have diagnosed:

HEALTH SCREENING EXAMS

Please mark all you have had and the approximate date/year of the test.

Chest X-ray:	CT scan:	EKG:	Stress Test:	Echocardiograms:	MRI:
Blood Testing:		Colonoscopy/Sigmoidoscopy:		Other:	
Women:	PAP Smear:	Mammogram:		Pelvic Ultrasound:	
Men:	Prostate Exam:	PSA Blood Test:			

FAMILY HISTORY

Have any blood relatives been diagnosed with the following (Please mark all that apply and family relation.)

Alcoholism:	Cancer:	Mental Health Problems:
Alzheimer's:	Depression:	Migraines:
Arthritis:	Diabetes:	Osteoporosis:
Autoimmune disorders:	Heart Disease:	Thyroid Problems:
Bleeding Disorders:	High Blood Pressure:	Colon/Digestive:
Cataracts/Glaucoma:	Kidney Disease/Stones:	Stroke:

SOCIAL HISTORY

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐Widowed

Do you live: alone with children spouse roommate significant other (male / female)

Do you have children:	Y	N	If so, how many?	
Do you sleep well?	Y	N	What are your hobbies?	
How is your energy level?	Poor	Fair	Good	Excellent
Are you sexually active?	Y	N	If yes, are you trying for a pregnancy?	Y N
Do you smoke/chew?	Y	N	How much?	

How much alcohol do you drink?

Do you currently use recreational or street drugs? Y N In the past? Y N

Have you traveled outside the United States? Y N If yes, where?

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Have you received a blood transfusion? Y N What is your blood type?

What is your occupation? How many hours a week?

NUTRITIONAL HISTORY

Are you dieting? Y N # of meals you eat in an average day?

How much per day or week: coffee: tea/kind: soda/kind:

Do you crave anything? Do you avoid anything?

Any food sensitivities or allergies?

Typical Breakfast	Typical Lunch	Typical Supper/Dinner	Typical Snacks

HEALTH HISTORY

GENERAL
_____Poor memory
_____Poor concentration
_____Headaches
_____Dizziness
_____Fainting
_____Poor sleep
_____Night sweats
Other_____

SKIN & HAIR
_____Rashes
_____Eczema
_____Hives/itching
_____Eruption/boils
_____Dry/rough skin
_____Bruise easily
_____Nails weak/ peel easy
_____Dry hair
_____Split ends
_____Hair loss
Other_____

EYES & EARS
_____Loss of vision
_____Blurry vision
_____Dry eyes
_____Sensitive to light
_____Itchy eyes
_____Earaches
_____Ear infections
_____Loss of hearing
_____Lot of wax
_____Ringing in ears
Other_____

LUNGS
_____Asthma
_____Wheeze
_____Cough frequently
_____Short of break w/ activity
_____Bronchitis/pneumonia history
_____Exposure to chemicals/fumes
Other_____

CARDIOVASCULAR
_____Fast heart rate
_____Irregular heart rate
_____Tightness in chest
_____Swollen feet/ankles
_____Leg pains with walking
_____Loss of hair on legs
_____Fainting
_____High blood pressure
_____History of heart attack
_____Varicose veins
_____Dizzy or weak when standing
Other_____

MOUTH & NOSE
_____Chronic congestion
_____Sore throats
_____Canker sores
_____Cold sores
_____Bleeding gums
_____Toothaches
_____Hoarse voice
_____Dry mouth
_____Poor taste/smell
Other_____

MUSCULOSKELETAL
_____Chronic pain location_____
_____Tremors/ twitches cramps
_____Neck Pain
_____Neck & Back Stiff
_____Numbness in Fingers/Toes
Other_____

URINARY
_____Urinate frequently at night
_____Urinate frequently during the day
_____Pain w/ urination
_____Bedwetting
_____Incomplete urination/dribbling
_____Narrowing/weakness of stream
_____Change in color/odor of urine
_____Kidney/bladder infections
_____Kidney stones
Other_____

GASTROINTESTIONAL
_____Loss of appetite or thirst
_____Difficulty swallowing
_____Nausea or vomiting
_____Not tolerating fats/greasy foods
_____Heartburn
_____Use antacids
_____Gas/burping/belching
_____Upper stomach bloating
_____Feel bad if skip meals
_____Diarrhea or loose stool
_____Mucous in stool
_____Undigested food in stool
_____Constipation
_____# of bowel movements in day
_____Hemorrhoids
_____Anal itching/bleeding
Other_____

PSYCHOLOGICAL
_____History of counseling/therapy
_____High stress
_____Preoccupations
_____Nervous breakdown
_____Paranoia
_____Depression
_____Anxiety
_____Insomnia
_____Panic attacks
_____Anger issues/bad temper
_____Irritable
_____Suicidal thoughts
Other_____

MEN
_____Discomfort/pain in genital area
_____Discharge from penis
_____Sore/rash on penis
_____Diminished sexual drive
_____Difficulty maintaining erection
_____Impotent
_____Testicle pain/swelling
_____Genital herpes
Other_____

WOMEN
Age of first period_____
# of days of flow_____
Length of cycles_____Days
Blood flow: light moderate heavy
Birth control:_____
# of pregnancies_____
# of children_____
# of miscarriages_____
Do you have your uterus? Y N
Do you have your ovaries? Y N
History of abnormal pap smear? Y N
Describe Premenstrual symptoms:
_____
_____
_____
_____

How many days before period, do you experience these symptoms?_____
Do you have:
_____Irregular periods
_____Pain w/ or prior to periods
_____Difficulty w/ constipation
_____Difficulty w/ orgasm
_____Diminished sexual desire
_____Ovarian cysts
_____Fibroids
_____Endometriosis
_____Vaginal infections
_____Genital herpes
_____Sexually transmitted infection
_____Painful intercourse
_____Hot flashes
_____Night sweats
_____Cry easy
_____Vaginal dryness
_____Breast tenderness
Other_____