Flourish, LLC

# Health History Questionnaire

Please take the time to fill out this questionnaire carefully. If you have any questions, ask for assistance. If you have any concerns that are not listed, make not of them on the back of this form. The completed form will greatly assist us in providing a thorough evaluation of your health.

Name: _____ Date of Birth: _____ Date: _____

## CONTEXT OF CARE

What brings you into the office today?

What are your main concerns? (Please list them in order of importance)

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

What long term expectations do you have from working with our clinic?

Are you currently receiving health care? (please circle) Yes No

If yes, where and from whom? _____

If no, when and where did you last receive health care? _____

What was the reason? _____

## FAMILY HISTORY

Do you have a family history of any of the following (please circle)?

| | | | |
|---|---|---|---|
| Cancer | Diabetes | Heart Disease | High Blood Pressure |
| Kidney Disease | Epilepsy | Arthritis | Glaucoma |
| Tuberculosis | Stroke | Anemia | Mental Illness |
| Asthma | Hay Fever | Hives | |

Other relevant family history?

## CHILDHOOD ILLNESSES

Please circle whether you have had any of the following as a child:

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| | | | |
|---|---|---|---|
| Rheumatic Fever | Diptheria | Scarlet fever | Chicken Pox |
| German Measles | Measles | Mumps | |

**CURRENT MEDICATION LIST**

Do you take any of the following (please circle):

| | | | |
|---|---|---|---|
| Laxatives | Pain Relievers | Antacids | Cortisone |
| Antibiotics | Tranquilizers | Sleeping Pills | Thyroid Medication |
| Birth Control Pills | Hormone Replacement | | |

Please list any prescription medications, over the counter medications, vitamins, or other supplements that you are taking with their dose:

| | |
|---|---|
| 1) | 6) |
| 2) | 7) |
| 3) | 8) |
| 4) | 9) |
| 5) | 10) |

**ALLERGIES**

Are you hypersensitive or allergic to any of the following? What happens if you have a reaction?

Medications? _____
Foods? _____
Environment? _____
Other? _____

**HOSPITALIZATIONS**

| What hospitalizations/surgery have you had? | Date |
|---|---|
| | |
| | |
| | |

**HEALTH HABITS**

| | | | If yes, how long or how much per week? |
|---|---|---|---|
| Do you exercise? | Y | N | |
| Do you smoke tobacco? (Now or in the past.) | Y | N | |
| Do you drink alcohol? | Y | N | |
| Do you use recreational drugs? | Y | N | |
| Do you drink coffee, soda, or, black tea? | Y | N | |
| Are you familiar with "safe sex" practices? | Y | N | |
| Do you eat regular meals? | Y | N | |
| Do you follow any dietary modifications? | Y | N | If yes, please describe: |

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| | | |
|---|---|---|
| Do you eat out often? | Y | N |
| Do you sleep well? How many hours/night? | Y | N |
| Do you awake rested? | Y | N |
| Do you spend time outside? | Y | N |
| Do you have a religious or spiritual practice? | Y | N |
| If so what kind? | | |

**MEDICAL HISTORY** For the following please circle:

Y = yes currently P = a significant problem in the past N = never had

| | | | |
|---|---|---|---|
| **GENERAL** | | | |
| Fatigue? | Y | P | N |
| Any unusual weight gain or loss? | Y | P | N |
| Perspire a lot? | Y | P | N |
| Feel cold or hot? | Y | P | N |
| Enjoy your work? | Y | P | N |
| Have supportive relationships? | Y | P | N |
| **ENDOCRINE** | | | |
| Hypothyroid? | Y | P | N |
| Hypoglycemia? | Y | P | N |
| Excessive thirst? | Y | P | N |
| Heat or cold intolerance? | Y | P | N |
| Hyper thyroid? | Y | P | N |
| Diabetes? | Y | P | N |
| Excessive Hunger? | Y | P | N |
| **HEAD** | | | |
| Headaches? | Y | P | N |
| Migraines? | Y | P | N |
| Head injury? | Y | P | N |
| Jaw or TMJ problems? | Y | P | N |
| **NECK** | | | |
| Lumps? | Y | P | N |
| Goiter? | Y | P | N |
| Difficulty swallowing? | Y | P | N |
| Pain or stiffness in neck? | Y | P | N |
| **EYES** | | | |

| | | | |
|---|---|---|---|
| Short of breath with exertion? | Y | P | N |
| Anemia? | Y | P | N |
| Easy bleeding or bruising? | Y | P | N |
| Cold hands/feet? | Y | P | N |
| Deep leg pain? | Y | P | N |
| Varicose veins? | Y | P | N |
| **GASTROINTESTINAL** | | | |
| Change in appetite? | Y | P | N |
| Abdominal Pain? | Y | P | N |
| Reflux or Heartburn? | Y | P | N |
| Nausea or vomiting? | Y | P | N |
| Excessive burping or gas? | Y | P | N |
| Ulcer? | Y | P | N |
| Constipation? | Y | P | N |
| Diarrhea? | Y | P | N |
| Hemorrhoids? | Y | P | N |
| Bowel Movements: How often? Recent change? | Y | P | N |
| Blood in stools? | Y | P | N |
| **GENITOURINARY** | | | |
| Burning or pain on urination? | Y | P | N |
| Change in frequency of urination? | Y | P | N |
| Incontinence? (inability to hold urine) | Y | P | N |
| Frequency at night? | Y | P | N |
| Frequent UTI's? | Y | P | N |
| KD / Bladder problems? | Y | P | N |
| Prostate problems? | Y | P | N |

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Pain or strain? | Y | P | N | **MUSCULOSKELETAL** | | | |
| Recent vision change? | Y | P | N | Back pain? | Y | P | N |
| Nearsighted or farsighted? (circle) | Y | P | N | Joint pain or stiffness? | Y | P | N |
| Tearing or Dryness? | Y | P | N | Broken bones? | Y | P | N |
| Cataracts? | Y | P | N | Weakness? | Y | P | N |
| Glaucoma? | Y | P | N | Muscle cramps or spasm? | Y | P | N |
| **EARS** | | | | **SKIN** | | | |
| Impaired Hearing? | Y | P | N | Change in color of skin? | Y | P | N |
| Ringing in ears? | Y | P | N | Rashes? | Y | P | N |
| Ear Aches? | Y | P | N | Dry skin ? | Y | P | N |
| Dizziness? | Y | P | N | New growth? | Y | P | N |
| **NOSE AND SINUS** | | | | Itching? | Y | P | N |
| Stuffiness? | Y | P | N | Acne? | Y | P | N |
| Sinus Problems? | Y | P | N | Eczema/hives? | Y | P | N |
| Nose bleeds? | Y | P | N | Have you ever head convulsions or fits? | | | |
| Loss of Smell? | Y | P | N | **NEUROLOGICAL** | Y | P | N |
| Do your gums bleed easily? | Y | P | N | Seizures? | Y | P | N |
| Do you have excess saliva? | Y | P | N | Muscle Weakness? | Y | P | N |
| **MOUTH AND THROAT** | | | | Loss of memory? | Y | P | N |
| Frequent sore throat? | Y | P | N | Vertigo or Dizziness? | Y | P | N |
| Sore tongue or lips? | Y | P | N | Paralysis? | Y | P | N |
| Hoarseness? | Y | P | N | Numbness or tingling? | Y | P | N |
| Jaw clicks? | Y | P | N | Easily stressed? | Y | P | N |
| Teeth grinding? | Y | P | N | Loss of balance? | Y | P | N |
| Gums bleed easily? | Y | P | N | **MENTAL/EMOTIONAL** | | | |
| Dental Cavities? | Y | P | N | Treated for emotional problems? | Y | P | N |
| | | | | | | | |
| **RESPIRATORY** | | | | Depression? | Y | P | N |
| Difficulty breathing? | Y | P | N | Anxiety or nervousness? | Y | P | N |
| Wheeze? | Y | P | N | Poor concentration? | Y | P | N |
| Constant cough? | Y | P | N | Mood swings? | Y | P | N |
| Sputum? | Y | P | N | Tension? | Y | P | N |
| Asthma? | Y | P | N | Memory problems? | Y | P | N |
| Cough up blood? | Y | P | N | **IMMUNE** | | | |
| Difficulty breathing? | Y | P | N | Reactions to immunizations? | Y | P | N |
| Shortness of Breath? | Y | P | N | Chronic swollen glands? | Y | P | N |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| “ “When lying? | Y | P | N | Slow wound healing? | Y | P | N |
| Pain on breathing? | Y | P | N | Chronic infections? | Y | P | N |
| Tuberculosis? | Y | P | N | Night sweats? | Y | P | N |
| Emphysema? | Y | P | N | **ENVIRONMENTAL EXPOSURE** | | | |
| **CARDIOVASCULAR** | | | | Worked with toxic chemicals | Y | P | N |
| Chest Pain? | Y | P | N | Exposed to chemical solvents? | Y | P | N |
| High or Low Blood pressure? | Y | P | N | Use oil paints? | Y | P | N |
| Heart Murmurs? | Y | P | N | Mercury amalgam fillings? | Y | P | N |
| Ankle or foot swelling? | Y | P | N | Exposed to toxic fumes? Eg: gasoline, exhaust fumes | Y | P | N |
| Heart beat fast or irregular? | Y | P | N | Exposure to heavy metals? | Y | P | N |
| Heart disease? | Y | P | N | Gardener? or Farmer? | Y | P | N |
| | | | | Silicone titanium implants? | Y | P | N |

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**GYNECOLOGY AND PREGNANCY *(women only):***

Please specify the number of: Births _____ Miscarriages _____ Abortions _____

Age at first period: _____ Age at menopause: _____ Regular cycles? Y/N

Duration of flow (days):_____ Time between cycles: _____ Date of last period _____

Flow (check one): ☐ Excessive ☐ Moderate ☐ Scanty

PMS? Y / N Symptoms: _____

Cramps (check one): ☐ Severe ☐ Mild ☐ None

Do you use birth control? Y / N Method of birth control:

Date of Last Gyn exam: _____ Date of Last Mammogram: _____

Do you have any of the following?

- ☐ Breast lumps
- ☐ Nipple discharge
- ☐ Vaginal dryness
- ☐ Infertility
- ☐ Frequent yeast infections
- ☐ Pain during intercourse
- ☐ Pain during orgasm
- ☐ Abnormal vaginal discharge
- ☐ History of genital warts
- ☐ History of abnormal pap
- ☐ Vaginal/vulvar itching
- ☐ Water retention
- ☐ Spotting between periods
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Herpes

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