



Dr. Kathleen Allen
Naturopathic Physician. Midwife. Lactation Consultant.

Health History Questionnaire

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

Name: _____ M F Date: _____ DOB: _____ Age: _____

Please list your present health concerns in order of their importance.

Concern:	Date of Onset:
_____	_____
_____	_____
_____	_____
_____	_____

What is your goal for this visit?

Please list any other healthcare providers you consult with.

Healthcare Provider:	Type of Practice:	Phone Number:
<i>Dr. Anna Smith (PCP)</i>	<i>DO</i>	<i>425.555.1212</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date of last physical exam:	Date of last pap/prostate exam:	Date of last fasting blood draw:
_____	_____	_____

Traumas, car accidents, injuries:

Please list prior hospitalizations:

Reason:	Date/Where:
_____	_____
_____	_____
_____	_____
_____	_____

Please list your previous medical diagnoses

1. Diagnosis _____	Date of Onset: _____	Doctor Involved: _____
Current symptoms: _____	Current treatments: _____	Treatments received in the past: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
What aggravates your condition? _____	What helps your condition? _____	In your mind, what caused this problem? _____
_____	_____	_____
_____	_____	_____
What do you hope for as we work together to treat this problem naturopathically? _____		

2. Diagnosis _____	Date of Onset: _____	Doctor Involved: _____
Current symptoms: _____	Current treatments: _____	Treatments received in the past: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
What aggravates your condition? _____	What helps your condition? _____	In your mind, what caused this problem? _____
_____	_____	_____
_____	_____	_____
What do you hope for as we work together to treat this problem naturopathically? _____		

3. Diagnosis _____	Date of Onset: _____	Doctor Involved: _____
Current symptoms: _____	Current treatments: _____	Treatments received in the past: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
What aggravates your condition? _____	What helps your condition? _____	In your mind, what caused this problem? _____
_____	_____	_____
_____	_____	_____
What do you hope for as we work together to treat this problem naturopathically? _____		

Please list any prescription medication you are currently taking..

Medication:	Reason:	Year Started:	Dosage:
<i>Eg. Lipitor</i>	<i>High cholesterol</i>	<i>2000</i>	<i>10mg once daily</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any over the counter medication you are currently taking.

Medication:	Reason:	Frequency:	Dosage:
<i>Eg. Advil</i>	<i>Pain relief</i>	<i>3 times/week</i>	<i>250mg twice daily</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any nutritional supplements, herbs, or homeopathics you are taking.

Supplement/Manufacturer/Form:	Reason:	Date Started:	Dosage:
<i>Eg. Quercetin/Natural Factors/capsules</i>	<i>Allergies</i>	<i>May 10, 2004</i>	<i>235mg 3x/daily</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any known allergies.

Drug Allergy:	Food Allergy:	Environmental Allergy:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Health History

Are you adopted? Yes No

	Current Age	Age of Death	Significant health problem or cause of death
Father			
Mother			
Brothers/Sisters (list)	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
Children (list)	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Please leave this space blank for doctor use

Childhood Medical History

Any complications during your mother's pregnancy with you? Yes No

If so, please describe: _____

Please check the box that describes how you were born:

Vaginal C-section Forceps Vacuum Trauma?

Any newborn problems?

Jaundice Extended hospitalization Other, please describe: _____

As a baby, were you fed:

Breastmilk Formula Mixed

Do you know at what age you were first given solid foods? _____

Please describe your diet as a child: _____

Please indicate if you had any of the following childhood illnesses.

Acne Chicken pox Mono pox Pertussis Rubella Scarlet Fever
 ADD Measles Mumps Polio Rheumatic Fever Other: _____

How often did you get sick as a child? _____

What kind of illnesses did you usually experience? *Eg. Ear infections, sore throat, cough, allergies, asthma...*

How often did you take antibiotics? _____

Please list any other medications taken regularly as a child. _____

Please describe your vaccination history.

I was fully vaccinated I was selectively vaccinated I was not vaccinated

Check the vaccinations that you've had:

Chicken pox Hepatitis B MMR Polio Other: _____
 DPT HIB Pneumonia PPD _____

Last tetanus booster: _____

Do you get the flu vaccine? _____

Have you ever had an adverse reaction to a vaccine? Yes No

Please describe your childhood home environment.

As a child, what adults lived with you? _____

Your birth order? *Eg. 3 of 5 kids* _____

Was your home safe? _____

Did you have any traumas or losses as a child? _____

Did you grow up in the city, suburbs or in a rural area? _____

Any difficulties in school? _____

Did anyone in your home smoke or use drugs regularly? _____

Other Lifestyle Factors

Please describe your physical activity level:

- Sedentary *Eg. No exercise*
- Mild exercise *Eg. Climb stairs, walk 3 blocks, golf*
- Occasional exercise *Eg. Work or recreation for 30 minutes duration less than 4 times weekly*
- Regular vigorous exercise *Eg. Work or recreation for 30 minutes more than 4 times weekly*

After moderate or vigorous exercise, how do you feel? Great Drained

Please list your current body weight: _____ **Desired body weight:** _____

What is the most _____ and least _____ that you have weighed as an adult (excluding pregnancy)?

Do you diet to lose weight? Yes No

Do you take medications, herbs, or supplements to lose weight? Yes No

Do you have, or have you ever had, an eating disorder? No Binging Purging Avoidance of food

BMI *Please leave blank for doctor use*

Please list the current members of your household. *Eg. Spouse, children, roommates, pets*

Name	Age	Relationship	Name	Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Is your home a sanctuary for you? Yes No

Is your home safe? Yes No

Does your home have lead paint? Yes No

Is there a gun in your home? Yes No

Is your home moldy? Yes No

Do you work primarily **inside** or **outside the home?**

Please list your present occupation. _____

How many hours a week do you work? _____

How many days a week do you work? _____

Do you spend more than half of your day at a desk or computer? Yes No

Do you take vacations? Yes No

Are you happy in your work? Yes No

Please check off any potential toxic exposures.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Glassblowing | <input type="checkbox"/> Painting | <input type="checkbox"/> Other mercury exposure |
| <input type="checkbox"/> Asbestos | <input type="checkbox"/> Lead paint | <input type="checkbox"/> Pesticides | <input type="checkbox"/> Other solvents |
| <input type="checkbox"/> Cleaning chemicals | <input type="checkbox"/> Mercury fillings | <input type="checkbox"/> Pottery | |
| <input type="checkbox"/> Electric power lines | <input type="checkbox"/> Model building | <input type="checkbox"/> Second-hand smoke | |
| <input type="checkbox"/> Frequent air travel | <input type="checkbox"/> Nuclear power plant | <input type="checkbox"/> Other heavy metals | |

Recall of Dietary Intake

Please list all foods and drinks you consume over the next 48 hours. Include meals, snacks, beverages and condiments.

Breakfast

	Food Item	Preparation <i>Eg. Baked, fried</i>	Amount
Day 1			
Day 2			

Lunch

	Food Item	Preparation <i>Eg. Baked, fried</i>	Amount
Day 1			
Day 2			

Dinner

	Food Item	Preparation <i>Eg. Baked, fried</i>	Amount
Day 1			
Day 2			

Snacks

	Food Item	Preparation <i>Eg. Baked, fried</i>	Amount
Day 1			
Day 2			

Alcohol Intake

Do you drink alcohol? Yes No What kind? _____ How many drinks/week? _____

Do you feel you drink too much? Yes No Have you ever experienced blackouts? Yes No

Are you prone to binge drinking? Yes No Do you feel guilty about your drinking? Yes No

Do you drive after drinking? Yes No Are you sensitive to criticism of your drinking?
 Yes No

Tobacco

Do you currently, or have you in the past, used tobacco? Yes No

Please check the box that applies to you.

Cigarettes Chew Pipe Cigars

___ packs/day ___ times/day ___ times/day ___ times/day

For how many years have you used tobacco products? _____

In what year did you quit using tobacco products? _____

Drug Use

Do you currently use recreational or street drugs? Yes No

Have you ever given yourself street drugs with a needle? Yes No

Caffeine

Do you drink coffee? Yes No Amount: _____

Do you drink soda? Yes No Amount: _____

Do you drink caffeinated tea? Yes No Amount: _____

Other: _____ Amount: _____

Elimination

Gut

How often do you have a bowel movement? _____

Does your stool have any of the following qualities?

- | | | | | |
|---|---------------------------------|---------------------------------|--------------------------------|---------------------------------|
| <input type="checkbox"/> Undigested food | <input type="checkbox"/> Formed | <input type="checkbox"/> Dry | <input type="checkbox"/> Tan | <input type="checkbox"/> Yellow |
| <input type="checkbox"/> Bright red blood | <input type="checkbox"/> Loose | <input type="checkbox"/> Greasy | <input type="checkbox"/> Black | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Mucus | <input type="checkbox"/> Hard | <input type="checkbox"/> Brown | <input type="checkbox"/> Green | |

Do you strain to pass stool? Yes No Do you experience gas bloating, belching? Yes No

Do you have hemorrhoids? Yes No Do you even unintentionally pass stool? Yes No

Please check any box that applies to you.

- | | | | |
|--|--|-----------------------------------|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Recent change in bowel habits |
| <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Constipation | <input type="checkbox"/> None | |

Kidneys

How often do you urinate? _____

Please check any box that applies to you.

- | | | |
|--|--|--|
| <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Must get up at night to urinate | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Urinate too frequently | <input type="checkbox"/> Leaking urine when coughing or laughing | <input type="checkbox"/> Recurrent urinary tract infection |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Leaking urine at other times | <input type="checkbox"/> Other |
| <input type="checkbox"/> Urinary flow obstruction | | <input type="checkbox"/> None |
| <input type="checkbox"/> Dribbling at end of urination | | |

Skin

Do you sweat easily? Yes No

Do you use antiperspirant? Yes No

Do you apply lotions or oils to you skin? Yes No

Do you scrub or dry brush your skin? Yes No

What type? _____

Please note if you have any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Pigment changes |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Contact dermatitis | <input type="checkbox"/> Hair loss or unusual growth | <input type="checkbox"/> None |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Moles | <input type="checkbox"/> Yellowing of the skin | |
| <input type="checkbox"/> Chronic itching | <input type="checkbox"/> Hives | | |

Liver

Please note if you have any of the following.

- | | | | |
|--|--|---|-------------------------------|
| <input type="checkbox"/> Yellowing of the skin | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> PMS | <input type="checkbox"/> None |
| <input type="checkbox"/> Chronic itching | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Menstrual irregularity | |

Are you unable to tolerate any of the following.

- | | | | |
|--|----------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Cigarette smoke | <input type="checkbox"/> Perfume | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Caffeine |
|--|----------------------------------|----------------------------------|-----------------------------------|

Review of Systems

Please check of you have, or have had, concerns in the following areas to a significant degree. Also note any recent changes in the areas listed below.

Constitutional

- Weight
- Energy level
- Sleep
- Appetite
- Strength
- Night sweats
- Sense of wellbeing
- Ability to sleep
- Libido
- None

Eyes, ears, nose, mouth, throat

- Vision loss
- Double vision
- Excessive tearing
- Dry eyes
- Blind spots
- Eye pain
- Eye discharge
- Hearing loss
- Ringing in the ears
- Vertigo/dizziness
- Nose bleeds
- Chronic stuffy nose
- Post nasal drip
- Recurrent sinus infection
- Headaches
- Missing teeth
- Gingivitis
- Bad breath
- Neck stiffness or swelling
- None

Heart and blood vessels

- Chest wall pain
- Palpitations
- Short of breath w/ mild exercise
- Short of breath lying flat
- Heart murmur
- Varicose veins
- Clotting disorder
- Vessel inflammation
- Fainting
- Swelling
- Leg pain when walking
- Anemia
- None

Lungs

- Painful breathing
- Shortness of breath
- Wheezing
- Cough
- Chronic bronchitis
- Coughing sputum
- Coughing blood
- None

Musculoskeletal

- Back pain
- Scoliosis
- Bone loss/fractures
- Muscle weakness
- Muscle cramps
- Muscle pain
- Joint pain
- Morning stiffness
- Hot/red muscles or joints
- Limited range of motion
- None

Neurologic and psychological

- Seizures/convulsions
- Paralysis
- Numbness/tingling
- Tremor
- Incoordination
- Speech difficulties
- Anxiety
- Depression
- Bipolar disorder
- Suicidal history
- None

Endocrine

- Breast enlargement – men
- Thyroid problems
- Heat or cold intolerance
- Excessive urination
- Excessive thirst
- Spacey feeling after food
- Waking at night
- Fainting
- Swelling
- None

Women's Health

Menstrual History

Age menses began: _____ Date of last menstrual period: _____
Length of cycle: _____ Duration of flow: _____
Date of last PAP: _____ Any history of irregular PAPs? Yes No
What best describes your current menstrual cycle:
 Regular Irregular Stopped Heavy Painful Other
Please describe any PMS symptoms you experience: _____

Sexual History

Are you sexually active? Yes No Are you in a monogamous relationship? Yes No
Have you ever had an STD screen? Yes No Have you ever had an STD? Yes No
If yes, please list: _____

Please check the box if you have, or have had, any of the following.

- Pain with sex Vaginal discharge Any sores, warts, or lesions
- Concerns about libido Hysterectomy Recurrent urinary tract infections
- Recurrent yeast infections

Fertility and Contraception

Number of pregnancies: _____ Any problems with pregnancies? Yes No
Number of births: _____ Any concerns regarding fertility? Yes No
Are you currently trying to get pregnant? Yes No If no, please describe your current method of birth control: _____

Breast Health

Please check the box that applies to you.

- Breast implants Rash Self breast exams
- Lumps or nodules Fibrocystic changes Clinical breast exams
- Nipple discharge None Annual mammograms Date last test: _____

Perimenopause/Menopause

Age menopause began: _____

Please check the box that applies to you.

- Hot flashes Low libido Fatigue Joint/body pain Change in memory/cognition
- Insomnia Irregular bleeding Palpitations Mood changes
- Vaginal dryness Heavy bleeding Urinary Tract Infections Depression None
- Pain with sex Incontinence Anxiety

Please describe any current treatment: _____

Bone Health

Please check the box that applies to you.

- Bone fracture No menses for > 1yr
- Smoker History of eating disorders
- Limited physical activity Weight < 125 lb