



Dr. Kathleen Allen  
Naturopathic Physician. Midwife. Lactation Specialist

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

Date of last physical exam: _____	Date of last pap/prostate exam: _____	Date of last fasting blood draw: _____
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Traumas, car accidents, injuries:

\_\_\_\_\_

Please list prior hospitalizations:

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

Please list your previous medical diagnoses

<b>1. Diagnosis</b> _____	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? _____		

<b>2. Diagnosis</b> _____	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? _____		

<b>3. Diagnosis</b> _____	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: <i>Eg. Lipitor</i>	Reason: <i>High cholesterol</i>	Year Started: <i>2000</i>	Dosage: <i>10mg once daily</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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

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

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

**Please list any known allergies.**

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

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

## 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)	M    F		
	M    F		
	M    F		
	M    F		
	M    F		
	M    F		
Children (list)	M    F		
	M    F		
	M    F		
	M    F		
	M    F		
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

*Please leave this space blank for doctor use*

Patient Name \_\_\_\_\_    DOB \_\_\_\_\_    Date \_\_\_\_\_

## 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? \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**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.**

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

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

### 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			

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_



## Elimination

### Gut

How often do you have a bowel movement? \_\_\_\_\_

Does your stool have any of the following qualities?

Undigested food	Formed	Dry	Tan	Yellow
Bright red blood	Loose	Greasy	Black	Other:
Mucus	Hard	Brown	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.

Abdominal pain	Nausea/vomiting	Diarrhea	Recent change in bowel habits
Heartburn/Indigestion	Constipation	None	

### Kidneys

How often do you urinate? \_\_\_\_\_

Please check any box that applies to you.

Pain with urination	Must get up at night to urinate	Kidney stones
Urinate too frequently	Leaking urine when coughing or laughing	Recurrent urinary tract infection
Urgency to urinate	Leaking urine at other times	Other
Urinary flow obstruction		None
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:

Acne	Dry skin	Skin cancer	Pigment changes
Eczema	Contact dermatitis	Hair loss or unusual growth	None
Rash	Moles	Yellowing of the skin	
Chronic itching	Hives		

### Liver

Please note if you have any of the following.

Yellowing of the skin	Nausea/vomiting	PMS	None
Chronic itching	Abdominal pain	Menstrual irregularity	

Are you unable to tolerate any of the following.

Cigarette smoke	Perfume	Alcohol	Caffeine
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Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

## Review of Systems

Please check if 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	Appetite	Sense of wellbeing	
Energy level	Strength	Ability to sleep	
Sleep	Night sweats	Libido	None

### Eyes, ears, nose, mouth, throat

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

### Heart and blood vessels

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

### Lungs

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

### Musculoskeletal

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

### Neurologic and psychological

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

### Endocrine

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

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

## 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  
Insomnia Irregular bleeding Palpitations Mood changes memory/cognition  
Vaginal dryness Heavy bleeding Urinary Tract Depression None  
Pain with sex Incontinence Infections 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

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_