COMPREHENSIVE HEALTH QUESTIONNAIRE

Patient Name: _____

Patient DOB: _____

Physician: _____

Please complete this packet to the best of your ability. All questions contained in this questionnaire are strictly confidential and will become part of your medical record. For additional information, write or attach on back. If you come across any highly sensitive issues that you find difficult to write about but you'd still like to discuss, just indicate the issue with an asterisk (*) and we will talk about it during your examination.

Name of Doctor: _____ Today's Date: _____

HEALTH HISTORY QUESTIONNAIRE

NAME (Last, First, M.I.):		**Male** □ **Female** □ **Other** □	**DOB**:	**DATE**:

PERSONAL HEALTH HISTORY

MEDICATIONS: List your prescriptions including OTC drugs such as vitamins, supplements and inhalers — □ **No medications taken**

Name of Drug	Strength	Frequency	Name of Drug	Strength	Frequency

ALLERGIES: Include antibiotics, narcotics, anesthetics, Iodine, IV, dye, latex, insect bites, pollen, food — □ **No known allergies**

Allergy	Reaction	Allergy	Reaction

MEDICAL HISTORY: Check all that apply, write in others — □ **No health problems**

Cardiovascular	□ High Blood Pressure □ High Cholesterol □ Angina □ Heart Attack □ Irregular Rhythm □ Congestive Heart Failure □ Heart Valve Problem □ Rheumatic Heart Disease □ Stroke □ Varicose Veins □ Rheumatic Fever □ Valvular Heart Disease □ Mitral Valve Prolapse □ TIA
Endocrine	□ Diabetes (year of onset: _____) □ Thyroid Disorder □ Adrenal Gland Disease
Pulmonary	□ Asthma □ COPD □ Emphysema □ Pneumonia □ Sleep Apnea □ Tuberculosis □ Valley Fever □ Chronic Bronchitis
Musculoskeletal	□ Arthritis □ Chronic Back Pain □ Fractures/dislocations □ Osteoporosis □ Spasms □ Restless Leg Syndrome
Gastrointestinal/ Esophageal	□ Diverticular Disease □ Esophageal Reflux (GERD) □ Hepatitis A/B/C □ Hemorrhoids □ IBS □ IBD □ Liver Problem □ Pancreas Problem □ Ulcer □ Bleeding
Renal	□ Kidney Stones □ Renal Failure □ Recurrent Urinary Tract Infections
Hematological	□ Anemia □ Blood Clots □ Blood Transfusion □ HIV Positive □ AIDS
Infectious	□ Sexually Transmitted Infection □ MRSA □ Lyme
Neurological	□ Migraine Headache □ Peripheral Neuropathy □ Seizures/Epilepsy □ Fainting Spells □ Parkinson's Disease □ Memory Disturbances □ Carpel Tunnel Syndrome □ Tremors
Ocular	□ Diabetic Eye Disease □ Cataracts □ Glaucoma □ Color Blind □ Glasses/Contacts □ Lasik Surgery □ Diabetic Retinopathy □ Macular Degeneration
Psychiatric	□ Depression □ Anxiety □ Bipolar Disorder □ Eating Disorder □ Obsessive Compulsive Disorder □ Adjustment Reactions □ Other:
Cancer	List Type:

Names/Types of Specialists currently seen:		
Hospitalizations in the last year	Date:	Location:
How many times pregnant?	**# Children**:	

Surgeries/Procedures — □ **No Surgeries/Procedures**

□ Appendectomy (Appendix)	Hysterectomy □ Partial □ Total	□ Coronary Stent	□ Vasectomy	□ Knee Procedure
□ Tonsillectomy	□ Cesarean Section	□ Coronary Bypass	□ Prostate Procedure	□ Hip Procedure
□ Gall Bladder (Cholecystectomy)	□ Tubal Ligation	□ Heart Valve Surgery	□ Colon Procedure	□ Back Procedure
□ Hernia Repair	□ Breast Procedure/Surgery	□ Cardiac Pacemaker	□ Eye Procedure	□ Sinus Procedure

□ Other Surgeries:

SOCIAL HISTORY AND HABITS

Tobacco	**Smoking Status:** □ Never Smoker □ Former Smoker □ Secondhand smoke exposure: high □ Secondhand smoke exposure: low □ Current every day Smoker □ Current some day Smoker □ Heavy tobacco Smoker □ Unknown tobacco status _____ Number of years smoking	**Tobacco Type** □ Cigarettes □ Cigars □ Oral □ Pipe □ Other:	**Describe your daily tobacco use** _____ # packs _____ # cigarettes _____ # chew	**Previous Quit Attempts** □ None □ Counseling □ Hypnosis □ Medications □ Nicotine replacement □ Other:

Caffeine	None	Coffee	Tea	Other	Amount per day?
Alcohol	Do you drink alcohol? □ Yes □ No		If yes, what type/amount per week?		
Drugs	Do you use recreational drugs? □ Yes □ No		Type:		Amount:
Sexuality	□ Heterosexual □ Homosexual □ Bisexual				
Marital Status	□ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed				
Employment/School	Occupation?		Place of employment/school?		
Personal/Safety	Who do you live with?				
	Do you typically wear a seat belt?				
	Do you have a medical power of attorney?		Do you have a living Will?		
	Do you feel threatened physically, sexually, verbally in your domestic relationship? □ Yes □ No				

FUNCTIONAL ASSESSMENT

Self-Care Ability		Independent	Require Assistance	Decline in Ability
	Ambulation/Mobility	□	□	□
	Chewing skills	□	□	□
	Stair climbing	□	□	□
	Bed mobility	□	□	□
	Drinking skills	□	□	□
	Hygiene/Bathing	□	□	□
	Toileting	□	□	□
	Dressing	□	□	□
	Eating skills	□	□	□
	Swallowing	□	□	□
	Speaking	□	□	□
	Cognition	□	□	□
Sensory Deficits	□ None □ Blind, left eye □ Blind, right eye □ Hearing deficit, left □ Hearing deficit, right □ Hearing Aid □ Cognitive deficit □ Sensation/touch deficit □ Uncorrected visual impairment □ Other:			
Medical Equipment	List Type (assistive devices, wheelchair, dentures, hearing aids, shower chairs, etc.)			

REVIEW OF BODY SYSTEMS

If you've experienced any of the below, please indicate (with an X) and describe any symptoms that you are currently experiencing or that are of concern to you.

GENERAL

□ Fevers □ Fatigue □ Weakness □ Change in Appetite □ Change in Weight
□ Cold or Heat Intolerance □ Abnormal Sweating □ Flushing □ Chronic Pain

HEAD/EYES

□ Headaches □ Dizzy Spells □ Faintness □ Seizures □ Loss of Consciousness
□ Change in Vision □ Visual Disturbances

EARS

□ Straining to Hear □ Missing Words □ Change in Hearing □ Noise in your Ears □ Ear Pain

NOSE

□ Nasal Congestion □ Obstruction □ Discharge □ Change in Smell

THROAT

□ Hoarseness □ Swollen Glands □ Persistent Sore Throat □ Neck Pain
□ Gum or Dental Disease □ Floss Regularly □ Do Not Floss Regularly □ TMJ

BREASTS

□ Pain □ Abnormal Lumps □ Skin Changes □ Nipple Discharge

RESPIRATORY

□ Cough □ Shortness of Breath □ Wheezing □ Change in Sputum

CARDIOVASCULAR

□ Chest Pains □ Palpitations □ Irregular Heart Beats □ Swollen Feet or Ankles
□ Varicose Veins □ Calf or Leg Pains with Walking □ Hypertension (year of onset: _____)

GASTROESOPHAGEAL

□ Nausea □ Vomiting □ Difficulty Swallowing □ Indigestion □ "Heartburn"
□ Abdominal Pain □ Bloating □ Burping □ Gas □ Symptoms of Reflux

INTESTINAL

□ Lower Abdominal Pain □ Constipation □ Diarrhea □ Excessive Flatus □ Hemorrhoids
□ Rectal Pain □ Rectal Bleeding □ Changes in shape, color, frequency, consistency of bowel Movements

URINARY SYSTEM

□ Increased Urinary Frequency □ Change in Urinary Stream □ Intermittent Stream
□ Pain or Burning with Urination □ Getting up at Night to Urinate (No. of times: ____)
□ Loss of Urine with coughing, sneezing, or effort □ History of Herpes or STDs: _____

MUSCULOSKELETAL

□ Arthritis-Joint Pains □ Neck or Back Pain □ Muscle Pain or Weakness □ Tendonitis □ Bursitis □ Gout
□ Foot Problems □ Change in Posture □ Disc Disease Disorder of Nerves or Muscles

SKIN, HAIR, NAILS

□ Rashes □ Itching □ Psoriasis □ Seborrhea □ Acne □ Dry or Oily Skin
□ Changes in Quality of Hair □ Excessive Hair Growth or Hair Loss □ Skin Cancers
□ Persistent Sores □ Abnormal Pigmentation □ Changes in Nails

NEUROLOGICAL

□ Changes in Memory □ Thinking □ Concentration or Speech □ Tremors
□ Difficulties with Movement of Extremities □ Change in Balance or Gait □ Disorders of Sensation

HEMATOLOGIC

□ Anemia □ Bruising □ Swollen Glands

FOR WOMEN
Age when Menses Began_____ Age at Menopause_____
□ Painful Menstruation □ Heavier or Lighter Periods □ Irregular Periods □ Vaginal Discharge
□ Vaginal Dryness or Irritation
Method(s) of Birth Control_____
□ # of Pregnancies (total)_____ □ # of Miscarriages _____ □ # of Abortions _____
□ Presently Pregnant or Breastfeeding □ Possibly Pregnant □ Change in Libido (sexual interest)
□ Any issues about sexual fulfillment or sexual activity with regard to self or partner?
If yes, please explain:
Have you taken or do you take hormone replacement therapy? □ Yes □ No
□ Early loss of ovarian function □ Hyperthyroidism □ Chronic diarrhea or intestinal malabsorption syndrome
□ Have had an eating disorder such as anorexia or bulimia □ Low calcium intake □ Little or no exposure to sun
□ High caffeine intake (2-3 cups/day) □ Perform physical activity excessively (causing missed periods)
□ History of inflammatory bowel disease □ Obesity □ History of colorectal cancer or polyps
□ Heavy alcohol use □ Inactive lifestyle

FOR MEN
□ Changes in Urinary Stream □ Changes in Libido (sexual interest)
Method(s) of Birth Control: _____
Any issues concerning… (check all that apply):
□ Premature Ejaculation
□ Erectile Dysfunction
□ Sexual Activity, or Fulfillment with Regard to Self or Partner
If yes, please explain: _____

NUTRITION SURVEY

Please check off and elaborate as necessary.

How would you rate your diet in general?

□ Very Healthy □ Healthy □ Moderately Healthy □ Unhealthy □ Very Unhealthy

Comments: _____

_____

_____

Please describe the healthy aspects and unhealthy aspects of your diet.

_____

_____

_____

Which improvements would you like to achieve:

□ Lower Salt
□ Lower Fat, Cholesterol
□ Less Oil, Butter, Mayo
□ More Calcium
□ More Calories, Fewer Calories
□ More Whole Grains, More Fiber

□ Less Candy/Chocolate
□ Fewer Cakes/Pies/Cookies
□ Less Bread, Potatoes, Rice, Pasta
□ Less Fried Food
□ Less Snack Food

□ More Fruits and Vegetables
□ More Carbohydrates

□ Less "Junk" Food - Describe:
□ Fewer Carbohydrates

□ More Protein
□ Less Fast Food
□ Less Alcohol
□ Fewer Pesticides

□ Less Protein
□ Less Meat, More Fish, More Soy
□ Smaller Portion Size

On average, what is the total number of servings of fruits and vegetables that you have each day? _____

Which fruits and vegetables do you like? _____

Which fruits and vegetables do you not like? _____

Do any of these apply to you? (check all that apply)

□ Milk intolerance □ hypoglycemia □ food allergies or other food intolerance

Would you like more information about nutrition? □ Yes □ No

What kind, how can we help you? (please explain) _____

_____

1-WEEK FOOD DIARY

Please complete the following food diary, logging your meals, snacks and drinks (including all non-alcoholic and alcoholic drinks consumed) for one week.

	BREAKFAST	LUNCH	DINNER	SNACKS	DRINKS
SUN					
MON					
TUES					
WED					
THURS					
FRI					
SAT					

EXERCISE HABITS

Please reply to questions and elaborate as needed.

How would you rate your present exercise habits?

□ Excellent □ Good □ Moderate □ Poor □ Very Poor

Please describe your present exercise habits (type and frequency):

List some of the benefits of exercise:

What have your exercise habits been like in the past?

Do you enjoy exercise? (Please comment)

What are some of your goals regarding exercise?

What has allowed you to reach your goals? What keeps you from 'reaching your goals?

Types of exercise you perform (please circle and comment below):

Swim Walk Jog Run Treadmill Roller Blade

Bicycle Basketball Baseball Sail Dance Golf

Tennis Tai Chi Judo Weight Lifting Handball Gardening

Gym Machines Aerobics Class House Cleaning Demanding physical labor at work

Other(s): _____

Comments:_____

_____

_____

_____

DOMESTIC & INTERNATIONAL TRAVEL HISTORY

Please reply to questions and elaborate as needed.

LIST OF PLACES TRAVELED WITHIN U.S. PAST 5 YEARS (INCLUDE YEAR):

_____
_____
_____
_____

LIST OF PLACES TRAVELLED INTERNATIONALLY PAST 5 YEARS (INCLUDE YEAR):

_____
_____
_____
_____

EVER BEEN SCREENED FOR TB BY SKIN TEST (PPD) OR CHEST X-RAY?

- ☐ NO
- ☐ YES
  - IF YES, WHEN? _____
  - WHERE? _____

IMMUNIZATIONS

Please indicate with an X whether you've had the following immunizations, and the date of your most recent vaccination.

Name of Immunization	Yes?	No?	Date
Influenza			
Pneumococcal PPSV23 (Pneumovax)			
Pneumococcal PCV13 (Prevnar)			
Hepatitis A series			
Hepatitis B series			
Tetanus booster (dT)			
Tetanus & pertussis booster (Tdap)			
Measles, Mumps, Rubella (MMR)			
Shingles (Zostavax)			
Diphtheria, Tetanus, & Acellular Pertussis			
Rotavirus (RV)			
Inactivated poliovirus			
Human Papillomavirus (HPV) *males and females*			
Meningococcal B			

PERSONAL & SOCIAL HISTORY

Please reply to questions and elaborate as needed.

Please provide a short work history. (Relevant present and past positions, type of work responsibilities.)

Please list some of your accomplishments to date. What are your future goals?

Tell us a little about your family. (Spouse, Parents, Siblings, Children, Grandchildren, etc.)

Tell us about your educational background or training.

What are your recreational interests? (Hobbies, pastimes, organizational work, etc.)

ALCOHOL USE:

Have you ever felt you needed to cut down on your drinking? □ YES □ NO

Have people annoyed you by criticizing your drinking? □ YES □ NO

Have you ever felt guilty about drinking? □ YES □ NO

Have you ever felt you needed a drink first thing in the morning (an "eye-opener") to steady your nerves or to get rid of a hangover? □ YES □ NO

AUTO SAFETY:

How often do you use your seatbelt? □ Always □ Sometimes □ Never

List the number of times in the past 10 years, that you as the driver OR the driver of the vehicle you were in, either fell asleep at the wheel or were too sleepy or tired to drive safely. _____

List the number of times, in the past 10 years, that you as the driver OR the driver of the vehicle you were in, was impaired by drugs or alcohol. _____

Do you tend to speed? □ YES □ NO Do you change lanes often? □ YES □ NO

Do you tend to be distracted by music or conversation? Do you use your cell phone frequently?

Do you take medication that might make you too sleepy or impair your driving?

ASSESSMENT OF RISK FACTORS: VISION, HEARING AND ORAL HEALTH: Please check Yes or No and elaborate as needed.

Date of most recent Eye Exam: _____ **Date of most recent Dental Exam:** _____

Yes No

- ☐ ☐ If you are 65 yrs. or older, do you see an eye doctor for regular annual eye exams?
  (If younger than 65, please leave blank)
- ☐ ☐ Do you have a history of glaucoma?
- ☐ ☐ Do you have a family history of glaucoma?
- ☐ ☐ Do you have a history of diabetes mellitus?
- ☐ ☐ Do you wear glasses or contact lenses?
- ☐ ☐ Do you see a dentist at least annually?
- ☐ ☐ Do you brush your teeth daily with toothpaste?
- ☐ ☐ Do you use dental floss?

ASSESSMENT OF RISK FACTORS: WOMEN'S HEALTH: Please check Yes or No and elaborate as needed. If male, please leave blank.

Yes No

- ☐ ☐ Have you had a Pap smear within the past 3 years?
- ☐ ☐ Are you currently or have you ever been sexually active?
  If yes, onset age of sexual activity? _____
  If yes, number of lifetime partners? _____
- ☐ ☐ Have you ever had an abnormal Pap smear?
  If yes, date of abnormal Pap smear ___/___/___
  What treatment(s) did you receive, if any? _____
- ☐ ☐ If you are 40 yrs. or older, have you had a mammogram within the past 1-2 yrs? (If younger, please leave blank)

ACCIDENT PREVENTION: Please describe any "at risk" behaviors, ego car racing, mountain climbing, gliding, etc. or other dangerous work or leisure pursuits.

Do you own a Gun? ☐ Yes ☐ No

If yes, measures for gun safety? _____

Do you use protective equipment as appropriate with exercise, work duties, and other activities you are involved in? (e.g. helmets pads, reflective night gear, protective eyewear, life preservers, seat belts, ear protection, other)

Please choose one: ☐ Always ☐ Sometimes ☐ Never

Please Explain: _____

FAMILY HISTORY: GENETIC AND ACQUIRED PREDISPOSITIONS

FAMILY HEALTH HISTORY

To the best of your knowledge, Do you have a parent, sibling, child with the following? Please select the family member(s). ☐ **Unknown** ☐ **Adopted**

	Father	Mother	Other- how related?		Father	Mother	Other- how related?
Cancer: Ovarian/Uterine				Osteoporosis			
Cancer: Breast				High Blood Pressure			
Cancer: Prostate				Elevated Cholesterol/Lipids			
Cancer: Colon				Multiple Sclerosis			
Cancer: Other type?				Ulcers/Stomach Disorders			
Diabetes				Bowel Polyps			
Heart Disease				Anxiety			
Hypertension				Mental Illness			
Brain Aneurysms (cerebral)				Depression			
Abdominal Aneurysms (Aortic)				Manic Depression			
Allergies/Asthma				Glaucoma			
Hearing Loss				Alzheimer's/Memory Loss			
Thyroid Disease				Obesity			
Stroke				Parkinson's			
Migraine Headaches				Other:			

LONGEVITY TREE

Please complete this family longevity chart to the best of your ability.

Person	Age if Living	Age at Death	Cause of Death
Mother			
Father			
Sister			
Sister			
Sister			
Brother			
Brother			
Brother			
Mother's Sister			
Mother's "			
Mother's "			
Mother's "			
Mother's Brother			
Mother's "			
Mother's "			
Mother's "			
Father's Sister			
Father's ..			
Father's ..			
Father's ..			
Father's Brother			
Father's. "			
Father's "			
Father's "			
Mother's Mother			
Mother's Father			
Father's Mother			
Father's Father			

DEPRESSION REVIEW

INSTRUCTIONS: **The following is a list of symptoms that people frequently have. Put a check in the space to the right that best describes how much that symptom or problem has bothered you during the past week.**	0 - Never	1 – Somewhat	2 - Moderately	3 – A lot
Sadness: Have you been feeling sad or down in the dumps?				
Discouragement: Does the future look hopeless?				
Low self-esteem: Do you feel worthless or think of yourself as a failure?				
Inferiority: Do you feel inadequate or inferior to others?				
Guilt: Do you get self-critical and blame yourself for everything?				
Indecisiveness: Do you have trouble making up your mind about things?				
Irritability and frustration: Have you been feeling resentful and angry a good deal of the time?				
Loss of interest in life: Have you lost interest in your career, your hobbies, your family or your friends?				
Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?				
Poor self-image: Do you think you're looking old or unattractive?				
Appetite changes: Have you lost your appetite, or do you overeat or binge compulsively?				
Sleep changes: Do you suffer from insomnia and find it hard to get a good night's sleep? Or are you excessively tired and sleeping too much?				
Loss of libido: Have you lost your interest in sex?				
Hypochondriasis: Do you worry a great deal about your health?				
Suicidal impulses: Do you have thoughts that life is not worth living or think that you might be better off dead?				

Add up your total score for the 15 symptoms and record it here: _____

USE OF COMPLIMENTARY OR ALTERNATIVE MEDICINE

Please describe any alternative medicine therapies that you have used or considered using in the past five years.

	Have Used	Have Considered Using	Please Describe Your Experience
Acupuncture			
Homeopathy			
Naturopathy			
Magnetic Therapy			
Herbal Remedies			
Chiropractic Therapy			
Massage			
Therapeutic Touch			
Meditation			
Guided Imaging			
Hypnosis			
Biofeedback			
Prayer			
Chelation Therapy			
Aroma Therapy			
Other (please describe):			

Comments:

_____

_____

_____

_____

THE EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING (0 - 3)
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE	

SCORE RESULTS:

1-6	Congratulations, you are getting enough sleep!
7-8	Your score is average
9 & up	Very sleepy and should seek medical advice

COMMENTS AND QUESTIONS

Feel free to use this space to write down any additional comments or questions you may have.