CENTER FOR INTEGRATIVE MEDICINE AND WELLNESS
7221 Pineville Matthews Road, Suite 200 Charlotte, NC 28226
Phone: (704) 543-2325 | Fax: (704) 543-5440

MEDICAL HEALTH HISTORY QUESTIONAIRE

Name_____DOB_____Age_____Date_____
Doctors you now see:_____
Doctors you have seen in the past_____
Current medical
problems:_____
_____
_____
_____
_____
Other concerns you would like to discuss with the
doctor:_____
_____
_____
List prescription medicines you now take (include dosage, reason you take it, who prescribed
it):_____
_____
_____
_____
_____
List over-the-counter medicines, vitamins, and food supplements you
take:_____
_____
_____
_____
Allergies:_____
Sensitivities:_____
_____
_____
_____
_____
Do/did you EXERCISE? _____How much? _____hrs/wk, # of years? _____ Year you
QUIT _____
Do/did you SMOKE? _____How much? _____packs/day, # of years _____ Year you
QUIT_____
Do/did you DRINK alcohol? _____ How much?_____drinks/week, #of years_____Year you
QUIT_____
Previous of current problem with
alcohol?_____AA?_____
Do/did you use (circle): caffeine NutraSweet marijuana cocaine chewing tobacco diet pills
Do you use seat belts? _____Do you wear sunscreen? _____Ride a motorcycle/bicycle?

List SURGERIES you have had (include year, surgeon, hospital):

_____

_____

_____

_____

Describe HOSPITALIZATIONS/ILLNESSES not included above (include year, hospital):_____

_____

_____

_____

_____

Have you had (circle):

1) migraines	2) hemorrhoids	3) mono	4) ulcer	
5) bleeding problem	6) blood clots	7) head injury	8) drug addiction	9) gallstones
10) tuberculosis	11) STDs	12) seizures	13) memory trouble	14) arthritis
15) psoriasis	16) heart murmur	17) rheumatic fever	18) polio	19) shingles
20) alcoholism	21) depression	22) mental illness	23) gout	24) hepatitis
25) hearing trouble	26) vision trouble	27) other: _____		

WOMEN

Age of first period_____Date of last normal period_____# of pregnancies_____

# of live births_____# of children living with you_____ birth control method_____

Date of last PAP _____Done where?

_____

Date of last mammogram_____Done where?_____

Do you have (circle):

Irregular periods	Bad menstrual cramps	Heavy periods	Pelvic pain	Infertility
Female trouble	Hot flashes	Vaginal dryness	Vaginal discharge	Vaginal odor
Vaginal itching	Abnormal PAP smear	Breast problems	Abnormal mammogram	PMS

MEDICAL HEALTH HISTORY QUESTIONAIRE – PART 2

List diseases that run in your family_____

_____

_____

Who in your FAMILY has/had (circle if cause of death and write age of death)

Heart disease_____
Diabetes_____
Thyroid disease_____
Mental illness_____
Glaucoma_____
Allergies_____
Tuberculosis_____
Genetic disorder_____
Cancer_____
Alcoholism_____
Arthritis_____
Asthma_____
Stomach problems_____
High blood pressure_____

Who lives in your

Where do/did you work?_____

Describe your education/upbringing, etc._____

How much do you weigh?_____ How much would you like to weigh?_____ Heaviest weight_____

When was your last:

1) Tetanus shot _____ 2) Flu shot_____ 3) EKG_____
4) TB test_____ 5) HIV test_____ 6) Sigmoidoscopy_____
7) Chest X-ray_____ 8) Pneumonia shot_____ 9) Hepatitis vaccine_____
10) Rectal exam_____ 11) Blood test_____

Describe your diet:_____

_____

Describe your skin problems:_____

_____

Describe your lung and breathing problems:_____

_____

Describe problems with your stomach, intestines, colon, digestion, bowel movements:_____

_____

Describe any urinary trouble_____

_____

Describe sexual concerns:_____

_____

Describe any bone, muscle, or joint problems:_____

_____

Describe any hormone problem_____

_____

Describe any problems with your thinking, concentration, moods, energy level, interest in life, etc.:_____

_____

Describe problems with strength, sensation, coordination, neurological function:_____

_____

Anything

_____
_____
_____
_____
_____
_____

Please sign and date:_____