

CENTER FOR INTEGRATIVE MEDICINE AND WELLNESS

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MEDICAL HEALTH HISTORY QUESTIONNAIRE

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 QUESTIONNAIRE – 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 _____	Genetic disorder _____
Diabetes _____	Cancer _____
Thyroid disease _____	Alcoholism _____
Mental illness _____	Arthritis _____
Glaucoma _____	Asthma _____
Allergies _____	Stomach problems _____
Tuberculosis _____	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: _____