



## CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

**Patient Name:** \_\_\_\_\_  
(Last) (First) (Middle)

**Date:** \_\_\_\_\_ PLEASE PRINT

\*Natural medical healthcare is possible only when the physician completely understands the patient's physical, mental and emotional condition. The information you provide helps the doctor understand your needs and how to help you reach your health goals. Please answer each question completely. Print all information and mark anything you have a question about.

Address \_\_\_\_\_  
STREET/ PO Box

\_\_\_\_\_  
CITY, STATE, ZIP

Phone \_\_\_\_\_  
HOME

\_\_\_\_\_  
MOBILE

\_\_\_\_\_  
WORK WITH EXTENSION

Best Reached At: (circle one) Home Mobile Work

SSN \_\_\_\_\_

Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Gender you identify with: \_\_\_\_\_

Gender on your birth certificate \_\_\_\_\_

Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_

NAME

PHONE NUMBER

RELATIONSHIP

How many children do you have? \_\_\_\_\_

Marital Status  Single  Married  
 Separated  Divorced  
 Other \_\_\_\_\_

With whom do you live?  Spouse  Friends  
 Parents  Alone  Children  
 Other \_\_\_\_\_

**In your opinion, what are your most important physical, emotional or mental health concerns? Indicate which are of the most immediate concern to you. (List primary healthcare concern first)**

1. \_\_\_\_\_

Date of onset: \_\_\_\_\_

2. \_\_\_\_\_

Date of onset: \_\_\_\_\_

3. \_\_\_\_\_

Date of onset: \_\_\_\_\_

4. \_\_\_\_\_

Date of onset: \_\_\_\_\_

Are you seeking primary care from 8 Hearts Health & Wellness?

Yes  No

If no, who is your primary health care physician?

NAME

PHONE (IF KNOWN)

For what concern did you last receive medical healthcare?

Date of care: \_\_\_\_\_

**How did you hear about 8 Hearts Health & Wellness?**

**Patient (or Guardian)**

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

Relationship to Patient (if other than self): \_\_\_\_\_



**CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE**

**MEDICATIONS AND SUPPLEMENTS**

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking?

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Check each that you currently use:

- |                                         |                                                 |                                              |                                             |
|-----------------------------------------|-------------------------------------------------|----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Laxatives      | <input type="checkbox"/> Pain relievers         | <input type="checkbox"/> Antacids            | <input type="checkbox"/> Cortisone          |
| <input type="checkbox"/> Antibiotics    | <input type="checkbox"/> Heart/Blood medication | <input type="checkbox"/> Allergy Medication  | <input type="checkbox"/> Thyroid medication |
| <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Anti-depressants       | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Hormones           |

Do you have any known contagious diseases at this time?     Yes     No    If yes, what? \_\_\_\_\_

**FAMILY HISTORY**

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
Current Health							
Age at Death							
Cause of Death							

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate the number of relatives who have the disease.

- |                     |                           |                      |
|---------------------|---------------------------|----------------------|
| Cancer _____        | Diabetes _____            | Epilepsy _____       |
| Heart Disease _____ | High Blood Pressure _____ | Stroke _____         |
| Anemia _____        | Kidney Disease _____      | Glaucoma _____       |
| Allergies _____     | Asthma _____              | Mental Illness _____ |
| Arthritis _____     | Tuberculosis _____        | Alzheimer's Dz _____ |

**CHILDHOOD ILLNESSES**

Have you had any of the following Childhood Illnesses? (check if yes)

- Scarlet fever     Diphtheria     Rheumatic fever     Mumps     Measles     German measles

Have you had any immunizations?     Yes     No    Negative Reactions? \_\_\_\_\_



## CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

### HOSPITALIZATIONS, SURGERIES, X-RAYS, SPECIAL STUDIES

What hospitalizations, surgeries, x-rays, or special studies have you had?

_____	Year: _____	_____	Year: _____
_____	Year: _____	_____	Year: _____
_____	Year: _____	_____	Year: _____

### ALLERGIES

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list:



### GENERAL

Weight: \_\_\_\_\_ lbs.                      Height: \_\_\_\_\_ Weight 1 year ago: \_\_\_\_\_ lbs.

Maximum Weight: \_\_\_\_\_ lbs. When: \_\_\_\_\_ Blood Type \_\_\_\_\_

Please list the most significant stressful events of your life (remember to include childhood):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### REVIEW OF SYMPTOMS

Answer questions or check any of the following you have or have had in the past 6 months.

#### LIFESTYLE HABITS

- |                                                            |                                                                      |
|------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Main interests and hobbies? _____ | <input type="checkbox"/> Take vacations                              |
| <input type="checkbox"/> Exercise, what kind? _____        | <input type="checkbox"/> Spend time outside                          |
| How often do you exercise? _____                           | <input type="checkbox"/> Watch TV? How much? _____                   |
| <input type="checkbox"/> Average 6-8 hrs. of sleep         | <input type="checkbox"/> Read? How often? _____                      |
| <input type="checkbox"/> Sleep well                        | <input type="checkbox"/> Drink alcoholic beverages? # per week _____ |
| <input type="checkbox"/> Awake rested                      | <input type="checkbox"/> Treated for alcoholism                      |
| <input type="checkbox"/> Have a supportive relationship    | <input type="checkbox"/> Use tobacco currently                       |
| <input type="checkbox"/> History of abuse                  | <input type="checkbox"/> Used tobacco in the past                    |
| <input type="checkbox"/> Major traumas                     | How many years? _____                                                |
| <input type="checkbox"/> Use recreational drugs            | How many packs per day? _____                                        |
| <input type="checkbox"/> Treated for drug dependence       | <input type="checkbox"/> Have a religious/spiritual practice         |
| <input type="checkbox"/> Drink coffee                      |                                                                      |
| <input type="checkbox"/> Drink black or green tea          |                                                                      |
| <input type="checkbox"/> Drink cola or other sodas         |                                                                      |
| <input type="checkbox"/> Add salt to your food             |                                                                      |
| <input type="checkbox"/> Eat refined sugar                 |                                                                      |
| <input type="checkbox"/> Enjoy your work                   |                                                                      |



## CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

### REVIEW OF SYSTEMS

Circle the response that applies  
 Y: condition you have now  
 P: condition you have had in the past  
 N: condition you have never had

#### SKIN

Rashes Y P N  
 Eczema, hives Y P N  
 Acne, boils Y P N  
 Itching Y P N  
 Color Change Y P N  
 Lumps Y P N  
 Night Sweats Y P N

#### HEAD

Headache Y P N  
 Head Injury Y P N

#### EYES

Impaired Vision Y P N  
 Glasses or contacts Y P N  
 Eye Pain Y P N  
 Tearing or dryness Y P N  
 Double Vision Y P N  
 Glaucoma Y P N  
 Cataracts Y P N

#### EARS

Impaired hearing Y P N  
 Ringing Y P N  
 Earache Y P N  
 Dizziness Y P N

#### NOSE and SINUSES

Frequent colds Y P N  
 Nose bleeds Y P N  
 Stiffness Y P N  
 Hay Fever Y P N  
 Sinus Problems Y P N

#### MOUTH and THROAT

Frequent sore throat Y P N  
 Nose bleeds Y P N  
 Hay fever Y P N  
 Sinus problems Y P N

#### NECK

Lumps Y P N  
 Swollen glands Y P N  
 Goiter Y P N  
 Pain or stiffness Y P N

#### RESPIRATORY

Cough Y P N  
 Sputum Y P N  
 Spitting up blood Y P N  
 Wheezing Y P N  
 Asthma Y P N  
 Bronchitis Y P N  
 Pneumonia Y P N  
 Pleurisy Y P N  
 Emphysema Y P N  
 Difficulty breathing Y P N  
 Pain on breathing Y P N

Shortness of breath Y P N  
     At night Y P N  
     Lying down Y P N  
 Tuberculosis Y P N

#### CARDIOVASCULAR

Heart disease Y P N  
 Angina Y P N  
 High Blood Pressure Y P N  
 Murmurs Y P N  
 Rheumatic fever Y P N  
 Chest Pain Y P N  
 Swelling in ankles Y P N  
 Palpitations, fluttering Y P N

#### GASTROINTESTINAL

Trouble Swallowing Y P N  
 Heartburn Y P N  
 Change in thirst Y P N  
 Change in appetite Y P N  
 Nausea Y P N  
 Vomiting Y P N  
 Vomiting blood Y P N  
 Bowel movements \_\_\_\_\_  
     How often? \_\_\_\_\_  
     Is this a change? \_\_\_\_\_

Blood in stool Y P N  
 Belching or passing gas Y P N  
 Jaundice (yellow skin) Y P N  
 Liver disease Y P N  
 Hemorrhoids Y P N

#### URINARY

Pain on urination Y P N  
 Increased frequency Y P N  
 Frequency at night Y P N  
 Inability to hold urine Y P N  
 Frequent infections Y P N  
 Kidney stones Y P N

#### FEMALE REPRODUCTIVE

Age menses began? \_\_\_\_\_  
 Average number of days? \_\_\_\_\_  
 Length of cycle? \_\_\_\_\_  
 Bleeding between periods Y P N  
 Are cycles regular Y P N  
 Pain during intercourse Y P N  
 Painful menses Y P N  
 Excessive flow Y P N  
 Birth control  Y  N  
 What type? \_\_\_\_\_  
 Number of pregnancies \_\_\_\_\_  
 Number of live births \_\_\_\_\_  
 Number of miscarriages \_\_\_\_\_  
 Number of abortions \_\_\_\_\_  
 Difficulty conceiving  Y  N  
 Menopausal symptoms Y P N  
 Are you sexually active?  Y  N  
 Sexual preference  Heterosexual  
                            Homosexual  
                            Bisexual

Sexual difficulties Y P N  
 Venereal disease Y P N

Do you do breast self-exam? Y P N  
 Lumps Y P N  
 Pain or tenderness Y P N  
 Nipple discharge Y P N

#### MALE REPRODUCTIVE

Hemias Y P N  
 Testicular masses Y P N  
 Testicular pain Y P N  
 Are you sexually active?  Y  N  
 Sexual preference  Heterosexual  
                            Homosexual  
                            Bisexual  
 Sexual difficulties Y P N  
 Prostate disease Y P N  
 Venereal disease Y P N  
 Discharge or sores Y P N

#### MUSCULOSKELETAL

Joint pain or stiffness Y P N  
 Arthritis Y P N  
 Broken bones Y P N  
 Muscle spasms or cramps Y P N  
 Weakness Y P N

#### PERIPHERAL VASCULAR

Deep leg pain Y P N  
 Cold hands/feet Y P N  
 Varicose veins Y P N  
 Thrombophlebitis Y P N

#### NEUROLOGIC

Fainting Y P N  
 Seizures Y P N  
 Paralysis Y P N  
 Muscle weakness Y P N  
 Numbness or tingling Y P N  
 Loss of memory Y P N

#### EMOTIONAL

Depression Y P N  
 Mood Swings Y P N  
 Anxiety or nervousness Y P N  
 Tension Y P N

#### ENDOCRINE

Hypo/Hyperthyroid Y P N  
 Heat or cold intolerance Y P N  
 Excessive thirst Y P N  
 Excessive hunger Y P N

#### BLOOD

Anemia Y P N  
 Easy bleeding or bruising Y P N

Name \_\_\_\_\_

Date \_\_\_\_\_