

PLEASE BRING THIS COMPLETED FORM TO YOUR APPOINTMENT

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Patient Questionnaire

Name _____ Date _____
Referred by? _____

What are your current symptoms and complaints?

- 1.
- 2.
- 3.
- 4.

PAST MEDICAL HISTORY: Please list significant medical problems (by decade) of your life:
Childhood illnesses:

Adolescence:

Forties:

Twenties:

Fifties:

Thirties:

Sixties plus:

PAST SURGICAL HISTORY: in chronological order including approximate year:

- | | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

MEDICATIONS and HORMONES: dosages and how often you take them:

- | | |
|----|----|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

SUPPLEMENTS: herbs, vitamins etc. and dosages:

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

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ALLERGIES:

HABITS:

Do you or have you smoked cigarettes, cigars? If so, how much and for how many years?

Alcohol: Type and frequency

Exercise: Type(s) and frequency

Caffeine: Type(s) and frequency

How much water do you drink each day?

What are the top two STRESSORS in your life?

- 1.
- 2.

Do you have SPIRITUAL life? If so, how would you describe it?

SOCIAL HISTORY:

Where were you born and where did you grow up?

Do you live alone?

Any pets?

Marriage(s):

Occupation(s):

Children and their ages:

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REVIEW OF SYSTEMS:

Do you currently have or have you ever had any of the following symptoms to a significant degree? (Mark each item with either Y or N. If Y, please explain.)

Headaches:

Post-nasal drip?

Chronic dental problems:

Shortness of breath:

Chest pains:

Chronic cough:

Do you have regular bowel movements?

Gas and or bloating:

Heartburn:

Diarrhea:

Constipation:

Is your sex drive satisfactory? (explain)

Frequent urination:

Urination at night:

Sugar cravings:

Interrupted sleep: (explain)

Insomnia (Explain):

Do you feel rested when you wake up?

Anxiety:

Depression:

Mood swings:

Irritability:

Night Sweats:

Fatigue (explain):

OTHER:

DIET:

Describe as specifically as possible a typical

Breakfast:

Lunch:

Dinner:

Snack(s):

Are you hungry before bedtime?

WOMEN: Approximate date of last:

Pap smear:

Mammogram:

Thermogram:

Sonogram

MEN:

Prostate problems

Satisfactory erections?

Any problems with urination?

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FAMILY HISTORY:

Family Member	Age if Living?	Age at Death	Cause of Death	Other medical conditions *
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Brother(s)				
Brother(s)				
Brother(s)				
Sisters(s)				
Sisters(s)				
Sisters(s)				

*Medical conditions of genetic significance such as cancer, diabetes, heart trouble, hypertension, stroke, nervous disorder, alcoholism, blood disease, arrhythmias, etc.