

communi•chi
Health History Questionnaire

Name _____

Date ____ / ____ / ____

Please complete this questionnaire as thoroughly as possible.

What condition(s) are your primary concerns in coming for treatment?

- 1)
- 2)
- 3)

Family History:

Please fill in the age and health information for family members. Place a checkmark where they have an applicable history.

	Father	Mother	Brothers	sisters	Child	spouse
Health (G=good; P=poor)						
Age, if living						
If deceased, age at death						
Cause of death						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, hay fever, hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						

Height _____ Current Weight _____ lb. Maximum Weight _____ lb. When? _____

Childhood Illnesses:

Scarlet Fever	Yes	No
Mumps	Yes	No
Chicken Pox	Yes	No
Diphtheria	Yes	No
Measles	Yes	No
Pneumatic fever	Yes	No
German measles	Yes	No

When? _____

Pertussis	Yes	No
Polio	Yes	No
Diphtheria	Yes	No
Other	Yes	No

Immunizations:

Measles/Mumps/Rubella	Yes	No
Tetanus	Yes	No

Allergies:

Are you hypersensitive or allergic to:

Any Drugs? Yes No Please List:

Any Foods? Yes No Please List:

Current Medications:

Please list any prescription medications, over the counter medications, vitamins, or other supplements you are currently taking:

Symptom Profile:

For the following, please check **YES** for a condition you have **currently** and check **PAST** for a condition you've had in the past, noting the date in the space provided.

Skin disorders:

Currently Have?	■YES	■PAST	When?
Acne, Boils	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acute Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Change	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema, Hives	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nail Fungus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rash	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Respiratory System Disorders:

Currently Have?	■YES	■PAST	When?
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain in Breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spitting Up Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Temporary Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Nasal Drainage to Throat

Other _____ _____

Emotional or Mental Illness:

Currently Have?	■YES	■PAST	When?
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Considered or Attempted Suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Head, Ear, Eyes, Nose, Throat:

Currently Have?	■YES	■PAST	When?
Head:			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears:			
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Impaired Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes:			
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Contacts or Glasses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain or Strain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Impaired Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tearing or Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spots in Front of Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose:			
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Smell	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mouth:			
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dental Cavities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Sores	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Thrush	<input type="checkbox"/>	<input type="checkbox"/>	_____
Teeth Grinding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jaw Problems, TMJ	<input type="checkbox"/>	<input type="checkbox"/>	_____

Throat:	■YES	■PAST	When?
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	_____
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Sore Throat			
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Digestive System Disorders:

Currently Have?	■YES	■PAST	When?
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gas or Bloating	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal Cramping	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loose Stool	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel Movement Frequency?			_____
- Is this a change?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Cardiovascular Disorders:

Currently Have?	■YES	■PAST	When?
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
Palpitations or Fluttering			
	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Urinary Tract Disorders:

Currently Have?	■YES	■PAST	When?
Frequent Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Night Urination			
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inability to Hold Urine			
	<input type="checkbox"/>	<input type="checkbox"/>	_____

Currently Have?	■YES	■PAST	When?
Burning or Pain during Urination			
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Increased Frequency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Musculoskeletal Disorders:

Currently Have?	■YES	■PAST	When?
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Spasms or Cramps			
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Pain, Swelling, or Stiffness			
Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any Other Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Location: _____			
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Miscellaneous:

Currently Have?	■YES	■PAST	When?
Easy Bleeding or Bruising			
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Slow Wound Healing			
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Day Sweats	<input type="checkbox"/>	<input type="checkbox"/>	_____
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cold Hands or Feet	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heat or Cold Intolerance			
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Fatigue Syndrome			
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hyperthyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive Thirst			
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive Hunger	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallbladder Disease			
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
- Type? _____			
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

