



Integrative Health Consults, LLC

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Medical History Questionnaire

Name _____ Date _____

Date of Birth _____ Age _____ Height _____ ft. _____ ins. Weight _____

Present Health Problem(s) and Description

Treatments and Results to Date

History of Present Illness: Describe how and when the problems began and progressed.

How long has it been since you were well? _____
Where were you living when you became ill? _____ What were you doing? _____

Current Medications, Dose and Frequency

Response to these Medications

Nutritional Supplements, Dose and Frequency

Response to Nutritional Supplements

How do you feel about using herbs and supplements? _____
How do you feel about using prescription medicine? _____

Allergies or sensitivities to drugs?

- Generally sensitive
- Anesthetics
- Penicillin
- Others: _____

Allergies to Inhalants?

- Dust
- Grass, trees, pollen
- Animal dander
- Mold

Sensitivities to chemicals and smells?

- Generally sensitive
- Cosmetics, detergents, perfumes
- Gas, glues, newsprint, paint, dye
- Chlorine, formaldehyde
- Others: _____

Name _____

Date _____

Surgeries and Hospitalizations:

Date

Injuries: (*sprains, fractures, dislocations and scars and organ removal*)

Date

Tests and Exams: Date of last completed physical: _____ Results: _____ By Whom: _____

Procedure/Test	Date	Results	Procedure/Test	Date	Results
Colonoscopy			MEN		
CT Scan			Prostate Exam		
DEXA/Bone Density			WOMEN		
EKG/Stress Test			Breast Exam		
MRI			Mammogram		
Flu Vaccine			Pap Smear		
Prosthetics			Silicon Implants		

FEMALES: Date of Last Menses _____ Number of Pregnancies _____ Number of Children _____ Pregnant? _____

Medical History: (Past and Present)

- | | | |
|----------------------------|-------------------------|------------------------------------|
| _____ Alcoholism/Addiction | _____ Epilepsy/Seizures | _____ Lyme Disease |
| _____ Allergies/Asthma | _____ Glaucoma | _____ Psychiatric Illness |
| _____ Arthritis | _____ Headache/Migraine | _____ Rheumatoid Arthritis |
| _____ Anxiety/Depression | _____ Heart Disease | _____ Sexually Transmitted Disease |
| _____ Cancer | _____ Hypertension | _____ Stroke |
| _____ CFIDS/Fibromyalgia | _____ Kidney Disease | _____ Thyroid: Hypo ___ Hyper ___ |
| _____ Diabetes | _____ Liver disease | _____ Viral: Herpes ___ CMV ___ |
| _____ Eczema/Skin Issues | _____ Lupus | _____ Polio ___ Mono ___ |

Other Diagnosis: _____

Family History: (any of which affected your parents, grandparents, siblings, children)

Relationship	Alive/Deceased	Present health conditions or cause of death
Grandparents	_____	_____
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
Children/ages	_____	_____

Check illnesses which have occurred in any of your blood relatives:

- | | | |
|----------------------------|---------------------------|----------------------------------|
| _____ Addiction | _____ Depression/Anxiety | _____ High Blood Pressure/Stroke |
| _____ Allergy/Asthma | _____ Diabetes | _____ Lyme Disease |
| _____ Alzheimer's/Dementia | _____ Digestive Issues | _____ Psychiatric Illness |
| _____ Arthritis | _____ Headaches/Migraines | _____ Obesity |
| _____ Cancer | _____ Heart Disease | _____ Thyroid Disease |

Dietary History: How often do you eat the following foods?

Meals per day: _____	Poultry: chicken, eggs ____ x week/month	Deli meats, bacon, ham ____x day/week/month
Snacks per day: _____	Fish and shellfish: ____x day/week/month	Sweets, candy, pastries ____x day/week/month
Water: _____ oz/day	Beans, peas, lentils: ____x day/week/month	Soft Drinks: ____x day/week/month
Prepare meals: ____ x day/week/month	Whole grains: oats, rice ____x day/week/month	Alcoholic Drinks: ____x day/week/month
Nuts and seeds: ____ x week/month	Bread, pasta, crackers ____x day/week/month	Coffee and tea: ____x day/week/month
Fruit: all kinds ____ x day/week/month	Dairy: milk, cheese: ____x day/week/month	Tobacco: ____x day/week/month
Vegetables: ____x day/week/month	Meat: beef, pork, lamb ____x day/week/month	Recreational Drugs: ____x day/week/month

1. Do you have any special dietary restrictions or preferences? _____
2. What foods do you crave if anything? _____
3. Where do you like to grocery shop? _____
4. What types of oils do you use for cooking, dressings, etc.? _____

Activity Level

Type of Activity

- _____ Sedentary (inactive) _____ by choice, or _____ due to inability or restriction.
- _____ Light (light daily work and/or exercise 1-2 times a week) _____
- _____ Moderate (light daily work and/or exercise 3 x a week) _____
- _____ Sustained (moderate daily work and/or exercise 5 x a week) _____
- _____ Heavy (heavy work and/or heavy exercise 6-7 x a week) _____
- Have you changed your exercise routine? _____

Stress/Life Management

1. I have a positive attitude about life. True _____ False _____
2. In my personal life, my stress level is: overwhelming _____ heavy _____ light _____ none _____
3. Have you changed your approach to dealing with stress? _____
4. I look forward to the future: never _____ sometimes _____ often _____ routinely _____
5. I feel at peace with myself: never _____ sometimes _____ often _____ routinely _____
6. I would like to improve myself in what ways? _____
7. My relationship status is: married, divorced, life partner, separated, single. Is this recent? Yes _____ No _____
8. What expectations were met? What expectations were not met? _____
9. My relationship with my partner is: great _____ good _____ ok _____ needs work _____ poor _____ N/A _____
10. My relationship with my children is: great _____ good _____ ok _____ needs work _____ poor _____ N/A _____
11. My job situation is: great _____ good _____ ok _____ needs work _____ poor _____ N/A _____
12. In my professional life, my stress level is: overwhelming _____ heavy _____ little _____ none _____
13. Are you having any difficulties at work? _____
14. How did you feel about this survey? _____

Sleep:

1. How many hours of sleep do you get a night? _____ Do you wake feeling rested? _____
2. During the day, I am tired: never _____ sometimes _____ often _____ routinely _____
3. Do you snore or have sleep apnea? _____

Name _____

Date _____

REVIEW OF SYMPTOMS

Check "PAST" or "NOW" when it applies RATE "NOW" 0-3 = 0 – Not Present 1 – Mild 2 – Moderate 3 – Severe

Symptoms	Past	Now	Comments	Symptoms	Past	New	Comments
ALLERGIES							
Seasonal Allergies				Own Dog/Cat			
Asthma				Head Congestion			
CARDIOVASCULAR SYSTEM							
High Blood Pressure				Dizzy Upon Standing			
Low Blood Pressure				Endocarditis, Heart Block			
Stroke				Heart Murmur, Valve Prolapse			
Chest Pain				Heart Palpitations			
Perspire Easily							
CONSTITUTIONAL							
Health Status : _____ Excellent _____ Good _____ Fair _____ Poor							
Migraines				Headaches			
Weight Gain				Unexplained Weight Gain			
Weight Loss				Unexplained Weight Loss			
Mild Fatigue				Extreme Fatigue, Poor Stamina			
Cold Extremities				Night Sweats			
Afternoon Drowsiness				Symptoms Come and Go			
Change in Appetite				Sensitivity to Alcohol			
Best Time of Day:	Worst Time of Day:			Sensitivity to Chemicals			
Best Season:	Worst Season:			Chills			
EARS, NOSE, MOUTH and THROAT							
Ear Infections				Pain in Ears			
General Hearing Loss				Sensitivity to Sounds			
Tongue Coated				Ringing, Tinnitus			
PND/Rhinitis				Plugged Ears, Decreased Hearing			
Sinusitis				Buzzing in Ears			
Sense of Smell Loss				Dental Pain			
Fillings: Mercury/Silver				Dental Problems, Unexplained			
Mouth Ulcers				Jaw Stiffness, Pain			
Bleeding Gums				Sore Throat, Hoarseness			
Bruxism (Grinding)				Phlegm, Clearing Throat			
Swallowing Problems				Runny Nose			
Jaw Pain/TMJ				Face Pain, Swelling			
Taste Loss							
Bad Breath							
ENDOCRINE							
Hot/Heat Intolerant				Low Body Temperature			
Cold/Cold Intolerant				Hunger Headaches, Irritability			
Thyroid Disorder				Hypoglycemia, Sensitive to Food			
EYES and VISION							
Wear Eye Glasses				Blurred Vision			
Blood Shot				Floating Spots			
Burning Dry Itching				Pain in Eyes			
Cataracts				Swelling Around Eyes			
Glaucoma/Retina				Light Sensitive			
Lids Crusty				Peripheral Waves, Phantom Images			
Night Blind							
DIGESTIVE SYSTEM							
Belching, Bloating, Gas				Constipation			
Trouble Digesting Fats				Diarrhea			
Hemorrhoids, Rectal Bleeding				Pain, Stomach or Abdominal			

Name _____

Date _____

Symptoms	Past	Now	Comments	Symptoms	Past	Now	Comments
Ulcer				Cramps, Low Abdominal			
Irritable Bowel				GERD/Heartburn			
Symptoms From Food				Bowel Habit Change			
				Nausea, Upset Stomach			
GENITO - URINARY SYSTEM							
Incontinence				Frequent Bladder Infections			
Kidney Stones				Irritable Bladder			
Pain, Burning with Urination				Interstitial Cystitis			
STD's				Dark Urine			
MALE							
Impotence				Erectile Dysfunction			
Urinary Frequency				Loss of Libido			
Prostate Problems				Testicular, Genital Pain			
FEMALE							
Endometriosis, Fibroids				Menstrual Irregularity			
Cramps, Heavy Flow				Menstrual Pain			
Infertility				Pelvic Pain			
PMS				Breast Pain			
Abnormal Pap Smear				Loss of Libido			
Painful Intercourse				Health Fluctuates with Cycle			
Fibrocystic or Sore Breasts				Unexplained Breast Discharge			
Peri-Menopausal							
Are you pregnant? _____ Yes _____ No							
Number of Pregnancies _____ Full Term _____ Miscarriages _____							
Menopausal: Natural _____ Surgical _____							
Hot Flashes							
Vaginal: Dryness							
Infections							
Yeast							
HEMATOLOGICAL							
Varicosities				Water Retention			
Anemia							
Bleeding Tendency							
Leg Pain with Walking							
Osteoporosis							
IMMUNOLOGICAL							
History of "Mono"				Unexplained Fevers (high or low grade)			
Autoimmune Disease				Persistent Swollen Glands			
Frequent Colds and Flu				Frequent Infections			
				Never well since infection or flu			
INTEGUMENTARY							
Acne, Eczema, Dermatitis				Crawling Sensation in Skin			
Itching, Burning, Dry				Tick Bite with Rash			
Oily				Various Rashes			
White Spots, Pigment Loss				Rash On and Off			
Yellow Tone				Frequency and Reaction to Mosquito Bites			
Nails: Brittle and Peeling				Skin Sensitivity			
Hair: Brittle, Dry				Sensitivity to Sunlight			
Male Pattern Baldness				Hair Loss, Unexplained			

Name _____

Date _____

Symptoms	Past	Now	Comments	Symptoms	Past	Now	Comments
MUSCULAR - SKELETAL							
Back Pain				Joint Pain, Swelling			
Symptoms Feel Better with Massage				Joint Stiffness, Tennis Elbow			
Intolerance to Exercise				Bone Pain			
Disc Problems				Carpal Tunnel Syndrome			
Bursitis/Tendonitis				Muscle Weakness			
Osteoporosis				Muscle Twitching, Spasms			
				Muscle Pain, Cramps			
				Sore Soles in Morning			
				Back Pain, Unexplained			
				Neck Stiffness, Pain			
NEUROLOGICAL							
Clumsy				Motion Sickness, Vertigo			
Raynaud's				Trouble Balancing, Topsy			
Head Injury				Dizziness			
				Numbness, Tingling			
				Tremors, Unexplained Shaking			
				Light Headedness			
				Burning, Stabbing Sensations			
				Seizures, Convulsions			
				Forgetting Simple Tasks			
				Disorientation, Confusion, Getting Lost			
				Difficulty with Reading and Concentration			
				Facial Paralysis, Bell's Palsy			
				Facial Tingling, Flushing			
				Speech Difficulty			
				Memory Problems			
				Word and Name Search			
PSYCHOLOGICAL and BEHAVIORAL							
Lack of Dream Recall				Narcolepsy-Oversleeping			
Vivid Dreams				Insomnia			
Eating Disorder (List)				Unusual Depression			
Addictions (List)				Emotional, Crying Easily			
Hyperactivity/Manic				Phobias			
Attention Deficit (ADD)				Anxiety, Panic Attacks			
Obsessive/Compulsive				Mood Swings, Bipolar			
Schizophrenia/Suicidal				Seasonal Affective Disorder			
Fearful/Worrier				Hallucinations, Delusions			
Depression				Psychosis			
For Children:				Feeling as though you are losing your mind			
Behavior Problems							
Learning Difficulty							
RESPIRATORY SYSTEM							
Asthma				Shortness of Breath			
Bronchitis				Chronic Cough			
				Chest Pain, Rib Soreness			
				Air Hungry			
				Snoring, Sleep Apnea			