SERENITY
NATURAL HEALTH

# Health History Questionnaire

Date: ___/___/___

**PATIENT CONTACT INFORMATION**

Name:_____ Date of Birth:____/_____/_____

Address:_____ City:_____ State:_____ Zip: _____

Phone Number:_____ O check here if you prefer that I **NOT** leave confidential messages

Email:_____

How did you find about about us? _____

O check here if you do NOT want to be keep up with Serenity Natural Health by newsletter

**EMERGENCY CONTACT INFORMATION**

Name:_____ Phone:_____

Relation:_____

**HEALTH CARE PRACTITIONER INFORMATION**

Primary Care Physician:_____

Clinic/Office Name:_____

Address:_____ City:_____ State:_____

Phone Number:_____ Fax Number:_____

Specialist #1:_____

Clinic/Office Name:_____

Address:_____ City:_____ State:_____

Phone Number:_____ Fax Number:_____

What is your main complaint today?_____

_____

_____

When did this problem begin? (Please be specific)_____

_____

What do you think caused it? Is the cause still present?_____

_____

What treatments have you tried already? What were the results?_____

_____

Name: _____ Date: _____

Have you been given a diagnosis for this problem? If so, what?_____

_____

To what extent does this problem interfere with your daily activities? (work, sleep, eating, sex...)_____

_____

_____

How severe is your problem right now? (Please mark the scale below)

No problem Moderate Worst Imaginable

What's the most severe level you have endured within the last week? (Please mark the scale below)

No problem Moderate Worst Imaginable

## Past Medical History (please indicate by date(s):

| | | | |
|---|---|---|---|
| Cancer _____ | High Blood Pressure _____ | Rheumatic Fever _____ | Venereal Disease _____ |
| Diabetes _____ | Heart Disease _____ | Seizures _____ | Asthma _____ |
| Hepatitis _____ | Stroke _____ | Thyroid Disease _____ | Pacemaker _____ |
| Other: _____ | | | |

Surgeries (type and date): _____

_____

Significant Trauma (auto accidents, falls, etc.): _____

_____

Birth History (prolonged labor, forceps delivery, caesarian section, other): _____

_____

Allergies (drugs, chemicals, foods, animals): _____

_____

Medications (with dosage): _____

_____

Supplements (vitamins, minerals, herbs, etc): _____

_____

Name: _____ Date: _____

## Family Medical History

| | | | |
|---|---|---|---|
| ☐ High Blood Pressure | ☐ Alcoholism | ☐ Cancer: _____ | ☐ Allergies: _____ |
| ☐ Heart Disease | ☐ Seizures | _____ | _____ |
| ☐ Arteriosclerosis | ☐ Asthma | _____ | _____ |
| ☐ Stroke | ☐ Diabetes | _____ | _____ |

Occupational Stress (chemical, physical, psychological, etc.): _____

_____

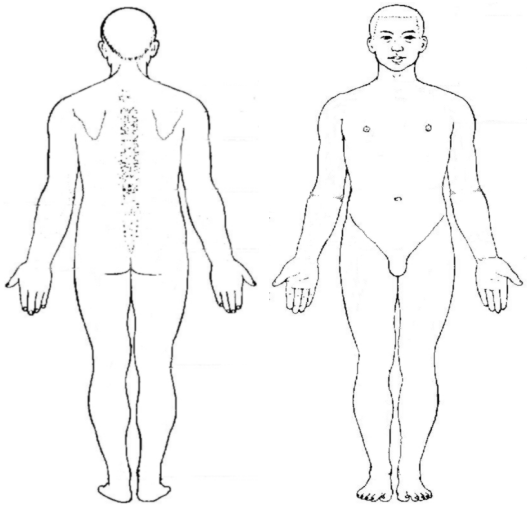
Do you exercise regularly? Y or N Please describe: _____

_____

Comments (please list any other problems you would like to discuss): _____

_____

## Indicate Painful or Distressed Areas



**What are Your Treatment Goals?**

☐ Temporary relief of symptoms/pain control

☐ Eliminate root or cause of problem (if possible)

☐ Lessen/eliminate habits which caused the condition or made it worse

☐ Maintenance care (periodic balancing/tune-up to keep in good health)

On the following page, please check any boxes of symptoms you have had in the past 2 weeks.

Name: _____ Date: _____

## General

- ☐ Chills
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold / hot)
- ☐ Thirst, no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drop
  *Time of day:*_____
- ☐ Edema
  *Where:*_____
- ☐ Poor sleeping
- ☐ Tremors
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight change
  *Gain / Loss* _____

## Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Oozing skin lesion
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff

*Other hair or skin problems*

_____

## Head, Eyes, Ears Nose, and Throat

- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches
  *When:*_____
  *Where:* _____
- ☐ Facial pain
- ☐ Glasses
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Color blindness
- ☐ Blind field
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Cataracts
- ☐ Eye Dryness
- ☐ Excessive tearing
- ☐ Discharge from eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Discharge from ear
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Nasal drainage
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Concussions
- ☐ Recurrent sore throats
- ☐ Hoarseness
- ☐ Sores on lips/tongue

*Other head / neck problems*

_____

## Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing

*Other heart/blood vessel problems:* _____

## Respiratory

- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Difficulty in breathing when lying down
- ☐ Phlegm *Color?*_____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis

*Other lung problems:*_____

_____

## Gastrointestinal

- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Black stools
- ☐ Abdominal pain/cramps
- ☐ Gas
- ☐ Rectal pain
- ☐ Hemorrhoids

*Other stomach or intestinal problems:*_____

_____

## Genito-Urinary

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sores on genitals

*Do you wake to urinate?*
☐ Yes ☐ No

*How often?* _____

*What color is your urine?*

_____

*Other genital or urinary system problems?*_____

_____

## Pregnancy and Gynecology

# of pregnancies: _____
# of births: _____
# premature births: _____
# of miscarriages: _____
# of abortions: _____
Age at first menses: _____
Length of full cycle: _____
Length of menses: _____
Last menses start date: _____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal discharge:
- ☐ Menopause:
  *Age:* _____
  *Year:* _____
- ☐ Postcoital bleeding
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Nipple discharge

*Do you practice birth control?*
☐ Yes ☐ No

*What type and for how long?*

_____

## Musculoskeletal

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Elbow pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Muscle pain
- ☐ Muscle weakness

*Other pain?* _____

_____

## Neuropsychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Weakness
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Bad temper
- ☐ Depression
- ☐ Easily stressed
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Substance abuse

*Have you ever been treated for emotional problems?*
☐ Yes ☐ No

Name: _____ Date: _____

## Last Physical Date: _____ Doctor: _____ Results: _____

## Habits Please indicate below: None, Light, Moderate, or Heavy. Please add comments where significant

| | Excessive | Moderate | Minimal | None | |
|---|---|---|---|---|---|
| Alcohol: | ☐ | ☐ | ☐ | ☐ | |
| Coffee: | ☐ | ☐ | ☐ | ☐ | |
| Tea: | ☐ | ☐ | ☐ | ☐ | |
| Tobacco: | ☐ | ☐ | ☐ | ☐ | |
| Exercise: | ☐ | ☐ | ☐ | ☐ | |
| Sleep: | ☐ | ☐ | ☐ | ☐ | |
| Appetite: | ☐ | ☐ | ☐ | ☐ | |
| Energy Level: | ☐ | ☐ | ☐ | ☐ | |
| Medication: | ☐ | ☐ | ☐ | ☐ | |
| Vitamins: | ☐ | ☐ | ☐ | ☐ | |
| Food Intake: | ☐ | ☐ | ☐ | ☐ | |
| Teeth problems: | ☐ | ☐ | ☐ | ☐ | |
| Drugs: | ☐ | ☐ | ☐ | ☐ | |
| Salt Intake: | ☐ | ☐ | ☐ | ☐ | |
| Other: | ☐ | ☐ | ☐ | ☐ | |
| Stress Level: | ☐ | ☐ | ☐ | ☐ | |

## Diet Please give a general description of the food you eat during a "typical" day.

Morning: .....

Afternoon: .....

Evening: .....

Before bed: .....

Between meals: .....

Are you now, or have you ever been, on a restricted diet? Please describe the diet and give the start/stop dates:

_____

_____