



HEALTH-HISTORY QUESTIONNAIRE

For your safety and optimal care, please type into the form, or print all information CLEARLY. Today's Date:

PATIENT INFORMATION

Last Name:	First Name:	Middle Init:
Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> (please explain) Race/Ethnicity:	Birth Date (MM/DD/YYYY):	Current Age:

CONTEXT OF CARE

Main Problem(s) you would like help with:
What expectations (list 1-3) do you have from <i>this visit</i> with me?
What <i>long-term</i> expectations do you have from working with me?
Do you have a primary care physician, or are you foreseeing working with me in that role?
What expectations do you have from me personally as your physician?
What is your present level of commitment to address any underlying causes of dis-ease that relate to your lifestyle? (Please rate from 0 to 10; 10 being 100% committed.)
Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?
Have you ever consulted a Naturopathic Doctor, Acupuncturist, Homeopath, Nutritionist, or Counselor before? Please summarize.
What are your health goals? What would you gain from improved health?

HEALTH HABITS

What behaviors/lifestyle habits do you currently engage in regularly that you believe support your health?
What behaviors/lifestyle habits do you currently engage in regularly that you believe are <i>not</i> health-supportive?
How many packs of cigarettes do you smoke per day? How many total "pack-years" – past and present combined, have you smoked ¹ ? How much alcohol do you drink per week (1 drink = 1 beer, 1 5oz glass wine, 1.5 oz hard alcohol): How many cups of coffee or cola do you drink per week? Please describe any recreational drug use:

¹ A "pack-year" is defined as 1 pack per day, per year, or the equivalent number of cigarettes. For example, ½ pack per day for 2 years would also be 1 pack year.

PRESENT STATE OF HEALTH

Allergies – drugs, chemicals, and/or foods (and the resulting reaction):
Do you have any known conditions, dis-eases, or diagnoses? If so, what are they? (if not, write “n/a”)
What kinds of treatment have you tried?
Are there known (or suspected) causative factors?
Have you found factors that either improve or aggravate your condition(s)? If so, which, and what are they?
Have you recently traveled outside the U.S.? When & where?

Please list prescription medications (with dosages) you are currently taking (or have taken in the last 2 months):		
Please list vitamins/minerals, herbs, or homeopathic remedies (with dosages) you are currently taking (or in last 2 mos.):		

Please fill in the relevant blanks, and check any of the following that a) has been present in the last 6 months or b) has been a significant or recurring symptom in the past.

General	Cardiovascular	Respiratory	Head/Eyes/Ears/Nose/Throat
<input type="checkbox"/> Fevers and/or Chills <input type="checkbox"/> Sweats or Night Sweats <input type="checkbox"/> Weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Sudden energy drop Time of day: _____ <input type="checkbox"/> Tremors <input type="checkbox"/> Poor balance <input type="checkbox"/> Cravings <input type="checkbox"/> Change in appetite <input type="checkbox"/> Unintended weight gain or loss	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chest discomfort/pain <input type="checkbox"/> Difficulty in breathing <input type="checkbox"/> Edema (swelling) Where? _____ <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Fainting <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Swelling of hands or feet <input type="checkbox"/> Blood clots <input type="checkbox"/> Bleed or Bruise easily <input type="checkbox"/> Anemia <input type="checkbox"/> Other: _____	<input type="checkbox"/> Recurrent respiratory infections <input type="checkbox"/> Cough <input type="checkbox"/> Asthma/wheezing <input type="checkbox"/> Pain/Difficulty breathing <input type="checkbox"/> Production of phlegm <input type="checkbox"/> Coughing blood <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis <input type="checkbox"/> Other: _____	<input type="checkbox"/> Migraines or Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Concussions/head trauma <input type="checkbox"/> Glasses or contacts <input type="checkbox"/> Changes in vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Eye discharge <input type="checkbox"/> Night blindness <input type="checkbox"/> Blurry vision <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Changes in hearing <input type="checkbox"/> Ear pain <input type="checkbox"/> Vertigo <input type="checkbox"/> Sinus problems <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Postnasal drip <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> Recurrent sore throat <input type="checkbox"/> Grinding teeth <input type="checkbox"/> Hoarseness <input type="checkbox"/> Oral or facial herpes <input type="checkbox"/> Other: _____
Please answer the following:			
Do you wake from sleep refreshed? _____			
How many hours/night do you sleep? _____			
Do you have trouble falling or staying asleep? _____			
Rate your perceived level of stress, 1-10 (10 is high): _____			

Gastrointestinal	Genitourinary	Sexual History	Menses/Women only:
<input type="checkbox"/> Nausea or Vomiting <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Pain/Difficulty swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Diarrhea <input type="checkbox"/> Belching or Gas <input type="checkbox"/> Indigestion <input type="checkbox"/> Constipation <input type="checkbox"/> Chronic laxative use <input type="checkbox"/> Blood in stools <input type="checkbox"/> Black or pale stools <input type="checkbox"/> Abdominal pain or cramps <input type="checkbox"/> Rectal pain <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Incomplete evacuation <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Fatigue or symptoms after eating. Noticeable after certain foods? _____ <input type="checkbox"/> Hepatitis <input type="checkbox"/> Jaundice <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pain on urination <input type="checkbox"/> Frequently waking to urinate. How many times/night, on avg: _____ <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney stones <input type="checkbox"/> Low or change in libido <input type="checkbox"/> Hormone therapy <input type="checkbox"/> Dribbling urination or weak flow <input type="checkbox"/> Men: testicular pain <input type="checkbox"/> Men: prostate problems <input type="checkbox"/> Men: erectile dysfunction <input type="checkbox"/> Yeast infection(s) <input type="checkbox"/> Women: vaginal itching <input type="checkbox"/> Women: strong vaginal odor <input type="checkbox"/> Other: _____	<input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Syphilis <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Genital Herpes <input type="checkbox"/> HPV (warts or cervical) <input type="checkbox"/> Discharge What color: _____ <input type="checkbox"/> Pain on intercourse Please answer: Are you presently sexually active? _____ With men, women, or both? _____ Do you ever engage in receptive anal intercourse? _____ Any gender identity issues? _____ Do you use birth control? _____ What type and for how long? _____ Women: how many years on hormonal forms of birth control? _____	<input type="checkbox"/> History of abnormal Pap <input type="checkbox"/> My mother took DES <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Breast pain or masses <input type="checkbox"/> Fibroids First day of last menses; _____ Number of pregnancies: _____ Number of living children: _____ Age at onset of menses: _____ <input type="checkbox"/> I am post-menopausal. Age at MP: _____ (go to next section) <input type="checkbox"/> I am peri-menopausal. <input type="checkbox"/> PMS <input type="checkbox"/> Pain w/menses <input type="checkbox"/> Irregular cycles <input type="checkbox"/> Bleeding betw. cycles <input type="checkbox"/> Very heavy or long flow Length of cycles (from Day 1 to next Day 1): _____ When was last Pap? _____
Please answer the following: How many bowel movements per day, on average? _____ Are your stools brown, formed and easy to pass? _____	Please answer: Any recent change in either bowel or urinary habits? _____		Office use only: G _____ P _____ LC _____ ToP _____ SAb _____

Endocrine	Neuropsychomotor	Skin/Hair	Musculoskeletal
<input type="checkbox"/> Heat/Cold intolerance <input type="checkbox"/> Goiter <input type="checkbox"/> Hormone Therapy <input type="checkbox"/> Diabetes <input type="checkbox"/> Hyper- or hypoglycemia <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tremor <input type="checkbox"/> Epilepsy or seizures <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Poor balance or coordination <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Areas of numbness <input type="checkbox"/> Areas of tingling, or shooting pain <input type="checkbox"/> Sleep disorder <input type="checkbox"/> Vertigo (dizzy, room spins) <input type="checkbox"/> Depression or mood disturbances <input type="checkbox"/> Difficulty w/attention <input type="checkbox"/> Poor memory <input type="checkbox"/> Anxiety	<input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Dandruff <input type="checkbox"/> Change in hair or skin <input type="checkbox"/> Loss of hair <input type="checkbox"/> Brittle nails <input type="checkbox"/> Pimples <input type="checkbox"/> New/changed moles <input type="checkbox"/> Eczema or psoriasis <input type="checkbox"/> Ulcerations <input type="checkbox"/> Other: _____	<input type="checkbox"/> Arthritis (joint pain) <input type="checkbox"/> Neck pain <input type="checkbox"/> Back pain. Where? <input type="checkbox"/> Unexplained back pain <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Upper limb pain <input type="checkbox"/> Lower limb pain <input type="checkbox"/> Foot pain <input type="checkbox"/> Muscle pains <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Other: _____
Allergic/Immunologic <input type="checkbox"/> Hives <input type="checkbox"/> Hay Fever <input type="checkbox"/> Allergies To what? _____ <input type="checkbox"/> Autoimmune disease (e.g. Lupus, Scleroderma, Rheumatoid Arthritis, etc)			Please answer: Any injuries or motor vehicle accidents in the last

	<input type="checkbox"/> Significant grief <input type="checkbox"/> Phobia(s): _____ <input type="checkbox"/> Substance abuse. What kind; how long? _____ <input type="checkbox"/> Mental illness: _____ <input type="checkbox"/> Other: _____		5 years? What and when? _____
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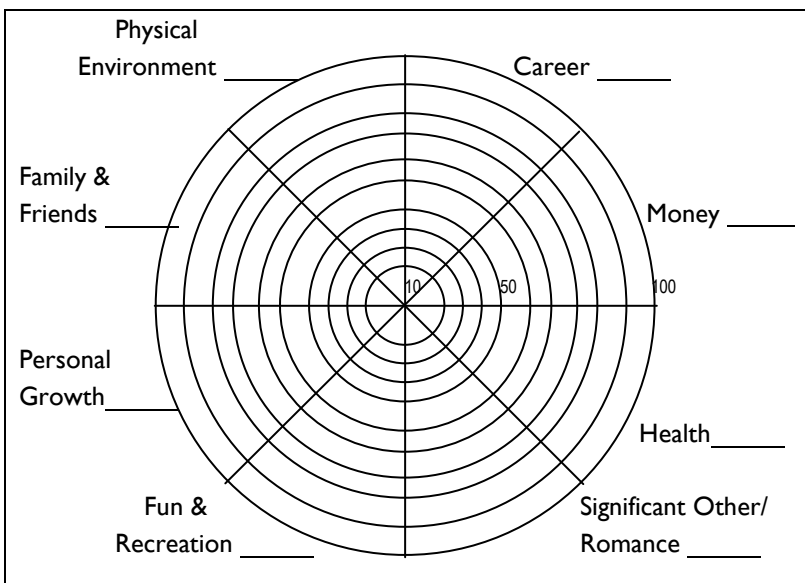
PAST MEDICAL HISTORY/FAMILY HISTORY

Have you or any first-degree relatives (or grandparents) ever had any of the following?

	Self. What year(s)?	Family. Who? (see codes*)
Transfusion or Transplant. What kind? _____		
Alzheimer's		
Heart Disease, Stroke or Diabetes. Which? Type, if known: _____		
Osteoporosis		
Bleeding Disorders. Type, if known: _____		
HIV, Syphilis, Gonorrhea		
Depression and/or Mania; or Mental Illness. Which? _____		
Liver or Kidney Disease		
Asthma, severe allergies, or anaphylaxis. What was the trigger? _____		
Addiction(s). To what? _____		
Crohn's or Colitis		
Any other diseases that run in the family? _____		
Cancer. What type? _____		
You only: Surgeries or hospitalizations. For what? _____		
You only: ever had Lyme Disease, Epstein-Barr virus, or mono?		

* F=Father M=Mother S=Sibling C=Child MGM=Maternal grandmother PGM=paternal GM MGF=maternal grandfather, PGF=paternal GF

SOCIAL HISTORY



Wheel of Balance

Wellness is a balance of many factors. Using the circle, assess your level of satisfaction in each area as it relates to you.

Shade the circle, or assign a number 0-100 for each pie-piece to represent the percentage 0-100% satisfaction you have for that area. For example, if you are extremely happy in your career, shade the entire pie-piece or write-in 100% for career.

Married? Partnered? Single? Children? Please briefly describe your home and living situation:
Who or what are your major sources of love/emotional support?
Who or what are your major sources of stress/anxiety/fear?

ENVIRONMENTAL EXPOSURES

Please check your exposure to the following sources of toxicity:

- Dental amalgams
- Exposure to lead, arsenic, or other heavy metals
- High levels of fish intake
- Recreational or pharmaceutical drugs (including contraceptive and other hormones)
- Background as pesticide or chemical applicator
- Exposure to excessive home or garden chemicals, or mold in the home
- Exposure to formaldehyde, or industrial or photographic solvents
- Daily consumption of alcohol
- I believe I have other significant toxic exposures (summarize): _____

YOUR PROVIDERS OF HEALTHCARE

Who is your primary care physician? Include name, phone number if you have it, their location (roughly), and type of degree (ND, MD, DO, ARNP, etc.)
Check here only if you do <u>NOT</u> want me to contact your other provider(s) regarding your care. <input type="checkbox"/>
Approximately how long ago was your last screening ("annual") physical exam?
Approximately how long ago was your last screening blood work?
Please check here if you are presently seeing or have seen any additional providers in the last 2 years (doctors, nutritionists, acupuncturists, etc.):

I affirm that, to the best of my knowledge and for the benefit of my own quality of care, the foregoing is true, correct, and complete. I further affirm that I will alert Dr. Epstein of any material changes to this information, including but not limited to changes in diagnoses or conditions, and changes in or additions of treatment by other providers, as such information can affect Dr. Epstein's prescriptions and/or recommendations to me.

Signature: _____ Date: _____

Printed Name: _____

Name/Relationship of person signing if patient is unable to, or under 18: _____

Office Use Only:

Reviewed form with patient on _____