wellbeing

NEW PATIENT
HEALTH HISTORY QUESTIONNAIRE

Name:	☐ **M** ☐ **F**	**DOB:**
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		**Referred by:**

Home Address	Telephone Numbers	OK for us to call you at this Number?
	Home Phone:	☐ Yes ☐ No
	Cell Phone:	☐ Yes ☐ No
City: State: Zip:	Work Phone:	☐ Yes ☐ No
Email:	Fax:	☐ Yes ☐ No

Occupation:	Family Physician:	Emergency Contact:

Past Personal Health History

Please identify the health concerns that have brought you to wellbeing in order of importance below:

Condition	Past Treatment	How does this condition affect you?

Height:	**Weight:**	Past maximum weight:	When:
Blood Pressure: Most recent reading:	When:	**Cholesterol**: Most recent reading: When:	

Have you had any of these childhood illnesses:

Rheumatic Fever ☐ yes ☐ no Diphtheria ☐ yes ☐ no Measles ☐ yes ☐ no Chicken Pox ☐ yes ☐ no

German Measles ☐ yes ☐ no Scarlet Fever ☐ yes ☐ no Mumps ☐ yes ☐ no

If applicable, please list any foods, drugs, or medications, or environmental factors you are hypersensitive or allergic to (please include reaction):

21121 Catawba Ave., Cornelius, NC 28031
ph 704 655-7324 fax 704 892-1083

Please list any medications (prescribed or over-the-counter), vitamins, and supplements that you are currently taking:

Please list any surgical procedures or hospitalizations you've had, for what reason, and when:

Health Habits and Lifestyle

Please describe your typical diet and how many meals you eat each day:
How many glasses of non-carbonated, non-caffeinated beverages do you drink each day:

Exercise
Please describe your exercise routine:

Alcohol Intake
Drinks per week: Are you concerned about this amount: ☐ yes ☐ no What type of alcohol:
Have you ever experienced "blackouts": ☐ yes ☐ no Are you prone to binge drinking: ☐ yes ☐ no

Tobacco
Do you smoke cigarettes: ☐ yes ☐ no How many cigarettes per day: How many years:
Do you use any other forms of tobacco: ☐ pipe ☐ chew ☐ cigar ☐ snuff Times per day: Years:
Have you ever tried to quit: ☐ yes ☐ no When: Would you like to quit: ☐ yes ☐ no

Recreational Drugs
Do you use recreational drugs: ☐ yes ☐ no How many times per week do you use:
Which drugs do you use: ☐ marijuana ☐ cocaine ☐ methamphetamines ☐ ecstasy ☐ LSD
☐ other (please explain):

Major Trauma
Please explain any major traumas you have gone through in your life:

Spiritual Practice
Feel free to describe your spiritual practice:

Television
How many hours a day do you watch TV:
Reading
How often do you read:

Sex
Are you currently sexually active: ☐ yes ☐ no Is there a chance that you are pregnant: ☐ yes ☐ no
Are you trying to get pregnant: ☐ yes ☐ no If not, what type of birth control do you use:
Any discomfort with intercourse: ☐ yes ☐ no
Have you ever contracted a sexually transmitted disease: ☐ yes ☐ no Which one(s):

Interests and Hobbies
Please tell us about your interests and hobbies:

Women's Health

Menstruation
Age at Onset of Menstruation: Date of last Menses: Length of Cycle:
Heavy Periods ☐ yes ☐ no Cramps ☐ yes ☐ no Spotting ☐ yes ☐ no Irregular Cycles ☐ yes ☐ no
Number of Live Births: Number of Miscarriages: Number of Abortions:
Breast Tenderness/ Lumps ☐ yes ☐ no Nipple Discharge ☐ yes ☐ no Difficulty Conceiving ☐ yes ☐ no

Menopause
Age at onset of Menopause: Date of last Menses:
Hot Flashes ☐ yes ☐ no Vaginal Dryness ☐ yes ☐ no Spotting ☐ yes ☐ no
Are you taking Hormone Replacement Therapy ☐ yes ☐ no
Any other symptoms (please explain):

Men's Health

Urination
Pain or burning with urination ☐ yes ☐ no Has the force of your stream decreased ☐ yes ☐ no
Do you get up to urinate at night ☐ yes ☐ no How many times:
Any blood in your urine ☐ yes ☐ no Any difficulty emptying the bladder completely ☐ yes ☐ no
Any discharge from the penis ☐ yes ☐ no Any testicular pain or swelling ☐ yes ☐ no
Any difficulty with erections or ejaculation ☐ yes ☐ no Any bladder, kidney, or prostate infections ☐ yes ☐ no
Do you have regular prostate and rectal exams ☐ yes ☐ no Approximate date of last exam

Family Health History

Check all that apply	Father	Mother	Grandmother	Grandfather	Sibling	Child
Age (if living)						
Health (G=Good, OK, P=Poor)						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						
Asthma/ Allergies						
Kidney Disease						
Alcoholism						
Domestic Violence						

Review of Systems

Please **check** all that you are experiencing now, **underline** those you've experienced in the past.

Emotional

Mood Swings ☐ Depression ☐ Anxiety ☐ Panic Attacks ☐

Suicide Attempts ☐ Frequent Crying ☐ Eating Disorders ☐ Insomnia ☐

Energy and Immunity

Fatigue ☐ Slow Wound Healing ☐ Chronic Infections ☐ Chronic Fatigue Syndrome ☐

Ear, Nose, Throat, and Head

Impaired Vision ☐ Eye Strain/ Pain ☐ Glaucoma ☐ Glasses/ Contacts ☐ Tearing/ Dryness ☐

Impaired Hearing ☐ Ringing of the Ears ☐ Earaches ☐ Headaches ☐ Sinus Problems ☐

Nose Bleeds ☐ Frequent Sore Throats ☐ Teeth Grinding ☐ TMJ/ Jaw Disorders ☐ Hay Fever ☐

Respiratory

Pneumonia ☐ Frequent Colds ☐ Difficulty Breathing ☐ Emphysema ☐

Persistent Cough ☐ Pleurisy ☐ Asthma ☐ Tuberculosis ☐

Shortness of Breath ☐ Other (please explain) ☐

Cardiovascular

Heart Disease ☐ Chest Pain/Angina ☐ Swelling of Ankles ☐ High Blood Pressure ☐

Palpitations ☐ Stroke ☐ Heart Murmur ☐ Rheumatic Fever ☐ Varicose Veins ☐

Gastrointestinal

Ulcers ☐ Changes in Appetite ☐ Nausea/ Vomiting ☐ Epigastric Pain ☐ Flatulence ☐

Heartburn ☐ Belching ☐ Gall Bladder Disease ☐ Liver Disease ☐ Hepatitis ☐

Hemorrhoids ☐ Abdominal Pain ☐ Irritable Bowel Syndrome ☐ Crohn's Disease ☐

Other (please explain) ☐

Genito-Urinary Tract

Kidney Disease ☐ Kidney Stones ☐ Painful Urination ☐ Frequent Urinary Tract Infections ☐

Frequent Urination ☐ Cloudy Urination ☐ Impaired Urination ☐ Blood in the Urine ☐

Frequent Urination at Night ☐ Incontinence ☐ Other (please explain) ☐

Musculoskeletal

Neck/Shoulder Pain ☐ yes ☐ no Muscle Spasms/ Cramps ☐ yes ☐ no Arm Pain ☐ yes ☐ no

Upper Back Pain ☐ yes ☐ no Mid Back Pain ☐ yes ☐ no Lower Back Pain ☐ yes ☐ no

Leg Pain ☐ yes ☐ no Joint Pain ☐ yes ☐ no If yes, please explain where:

Other (please explain):

Neurological

Vertigo/Dizziness ☐ yes ☐ no Paralysis ☐ yes ☐ no Numbness/Tingling ☐ yes ☐ no

Loss of Balance ☐ yes ☐ no If yes, do you live alone ☐ yes ☐ no Have someone helping you ☐ yes ☐ no

Seizures/Epilepsy ☐ yes ☐ no If yes, are you taking medications ☐ yes ☐ no Fainting ☐ yes ☐ no

Endocrine

Hypothyroid ☐ yes ☐ no Hyperthyroid ☐ yes ☐ no Hypoglycemia ☐ yes ☐ no

Diabetes Mellitus ☐ yes ☐ no If yes, are you insulin-dependent ☐ yes ☐ no

Night Sweats ☐ yes ☐ no Feeling hot or cold ☐ yes ☐ no

Other

Anemia ☐ yes ☐ no Cancer ☐ yes ☐ no Rashes ☐ yes ☐ no

Eczema/Hives ☐ yes ☐ no Cold Hands/Feet ☐ yes ☐ no

Is there anything else we should know?