General Health History Questionnaire

(To be completed by patient)

Name: _____ Date: _____
Date of Birth: _____ Age: _____
Sex: M / F (circle one) Weight: _____ Height: _____
Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____
Work #: _____ Email: _____
In Case Of Emergency name & #: _____

Chief Complaint(s): _____
_____
_____
_____

Prescription Drug Usage – Please check if you use any of the following & then list exact names of any medications you are currently using:

- ☐ Antacids, Zantac, Pepcid, AC, Rolaids, Etc.
- ☐ Chemotherapy
- ☐ Laxatives
- ☐ Ulcer Medications
- ☐ Antibiotic/Antifungal
- ☐ Anti-diabetic/Insulin
- ☐ Oral Contraceptives
- ☐ Hormones – if so What? _____ When? _____ Dosage? _____
- ☐ Relaxants/Sleeping Pills
- ☐ Thyroid
- ☐ Radiation
- ☐ Antidepressants
- ☐ Aspirin/Acetaminophen
- ☐ Cortisone/Anti-Inflammatory
- ☐ Heart Medications
- ☐ High Blood Pressure

Please List names of any medications you are currently taking: _____
_____
_____
_____
_____

Are you allergic to any drugs, and if so please list the names here: _____
_____
_____

Are you Lactose or Gluten Intolerant: (please circle one) LACTOSE GLUTEN BOTH

Are you allergic to any foods, and if so please list the names here: _____
_____
_____

Supplement/Vitamin Usage – Please list any supplements/vitamins you are currently taking: _____
_____
_____

~ Life Style ~

Dietary Habits – Describe the foods you normally eat:
BREAKFAST: _____
LUNCH: _____
DINNER: _____
SNACKS: _____

Do you consume the following…?			If so, how much?
1. Soda or carbonated beverages?	YES	NO	_____
2. White flour products?	YES	NO	_____
3. Fried food?	YES	NO	_____
4. Coffee?	YES	NO	_____
5. Fast food regularly?	YES	NO	_____
6. Sweets and/or refined carbohydrates?	YES	NO	_____
7. Alcoholic beverages?	YES	NO	_____
8. Any tobacco products?	YES	NO	_____

Are you a vegetarian? YES NO

Are you currently in an exercise program? YES NO How often? _____

How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

~ Males Only ~

Have you had a vasectomy? YES NO When? _____
Reverse vasectomy? YES NO When? _____

Experienced any symptoms related to the vasectomy/reverse vasectomy? YES NO
If yes, please explain: _____
_____

Do you have any history of prostate problems? YES NO
If yes, please explain: _____
_____

When was your last prostate exam: _____
What were your most recent PSA results? _____ Date: _____
Does your bladder always feel full? YES NO SOMETIMES
Does ejaculation cause pain? YES NO SOMETIMES
Do you ever experience low sex drive? YES NO SOMETIMES
Do you have premature ejaculation? YES NO SOMETIMES

All men completing this form should now skip the next few sections and start again in the section titled "Sleep" and continue with the remainder of this questionnaire.

~ Females Only: Reproductve Health History ~

(To be completed by all women, if applicable)

Age at onset of first period: _____ Approximate date of onset: _____

What are you using for contraception at the moment? _____

Have you ever used **oral**, **injection**, **patch**, or **ring** hormone contraceptives, or used Emergency Contraceptives ("The day after pill")? YES NO
If yes, from _____ to _____.
Did you suffer from any side effects from contraceptives? YES NO
If yes, please explain: _____

Are you currently or have you ever used an IUD? YES NO
When? _____ and for how long? _____

~ Sleep ~

How well do you sleep? (circle all that apply)

Well Trouble Falling asleep Trouble staying asleep Insomnia

What is the average number of hours you most often sleep each night? _____

Do you wake up with night sweats? YES NO

When you wake in the morning do you still feel tired? YES NO

If yes, how often? _____

Do you keep your room completely dark at night? YES NO

~ Signs & Symptoms ~

Instructions: circle the number that best describes the intensity of your current symptoms. 1 = mild (approximately once per month), 2 = moderate (approximately weekly), 3 = severe (almost daily). If you do not know the answer to a question or if it does not apply to you simply leave it blank.

Section 1:

Do you experience bloating?	1	2	3
Fullness for extended time after meals?	1	2	3
Fatigue or low energy after eating?	1	2	3
Do you experience indigestions?	1	2	3
Uncomfortable/adverse reactions to food?	1	2	3
Weight gain?	1	2	3
Trouble losing weight?	1	2	3
Weight loss?	1	2	3
Water Retention?	1	2	3
Belching/Gas? (circle)	1	2	3
Stomach burning/nausea? (circle)	1	2	3

Section 2:

Do you suffer with constipation?	1	2	3
Light colored stool?	1	2	3
Loose stools?	1	2	3
Diarrhea?	1	2	3
Persistent gas?	1	2	3
Digestive problems?	1	2	3

Section 3:

Low blood sugar/hypoglycemia?	1	2	3

Sweet cravings?	1	2	3
Carbohydrate cravings?	1	2	3
Caffeine/stimulant cravings? (circle)	1	2	3
Constant hunger?	1	2	3

Section 4:

Low mood/depression? (circle)	1	2	3
Mood swings?	1	2	3
Irritability?	1	2	3
Anxiety?	1	2	3
Anger/aggression?	1	2	3
Nervousness?	1	2	3
Overly reactive?	1	2	3
Short fuse?	1	2	3

Section 5:

Discouragement/pessimism? (circle)	1	2	3
Decreased interest in activities/relationships? (circle)	1	2	3
Decreased initiative/motivation/drive? (circle)	1	2	3
Decreased productivity at work?	1	2	3

Section 6:

Concentration problems?	1	2	3
Poor memory?	1	2	3
Foggy thinking?	1	2	3
Increased fatigue?	1	2	3
Lowered self-esteem/self image? (circle)	1	2	3
Care for others before yourself?	1	2	3
Sadness/crying? (circle)	1	2	3

Section 7:

Decrease in strength/stamina? (circle)	1	2	3
Decrease in athletic performance?	1	2	3
Decrease lean muscle mass?	1	2	3
Muscle soreness/weakness? (circle)	1	2	3
Body/joint aches? (circle)	1	2	3
Increased fat on hips/breasts/thighs? (circle)	1	2	3
Poor stamina?	1	2	3
Persistent leg cramps?	1	2	3

Section 8:

Elevated cholesterol?	1	2	3
Elevated blood pressure?	1	2	3
Headaches/migraines? (circle)	1	2	3
Muscle pain/joint aches/backaches?	1	2	3

Section 9:

Head hair loss/body hair loss? (circle)	1	2	3
Dry skin?	1	2	3

Section 10: (Females Only)

Infertility?	1	2	3
Lowered/heightened libido? (circle)	1	2	3
Hot flashes?	1	2	3
Night sweats?	1	2	3
Palpitations?	1	2	3
Breast tenderness?	1	2	3
Breast cysts?	1	2	3
Vaginal infections/yeast infections? (circle)	1	2	3
Urinary frequency/incontinence/infections? (circle)	1	2	3
Changes to labia/clitorial tissue? (circle)	1	2	3
(Atrophy, thinning, discoloration, itching, burning, …)			
Vaginal changes (dryness, tearing, decreasing size)? (circle)	1	2	3
Bone loss/osteoporosis?	1	2	3
Endometriosis?	1	2	3
Pelvic Inflammatory Disease?	1	2	3
Cystitis?	1	2	3
Ovarian cysts?	1	2	3
Fibrodes?	1	2	3

Section 11: (Males Only)

Lowered Libido?	1	2	3
Erectile Dysfunction (ED)?	1	2	3
Pain w/ejaculation?	1	2	3
Frequent need to urinate?	1	2	3
Urination is delayed/strained/incomplete? (circle)	1	2	3
Pain with urination?	1	2	3
Blood in the urine?	1	2	3
Bone loss/osteoporosis?	1	2	3