Dr. Pea's Active Health Center

Health History Questionaire

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Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a major role in diagnosis and treatment.

All information is strictly confidential.

I. General Patient Information

Date: ____/____/____ Name: ____

Address: ______________________City________________ State________ Zip: ________

Home Ph: (____) ____________Work Ph: (____) ____________ Cell Ph: (____) ____________

Age: ______ Date of Birth: _____/____/_____ Place of Birth: ______________________________

Email address: ______________________Guardian (if under 18): ______________________

Gender: ☐ M ☐ F Height: ___'___" Weight: ______lbs. Social Security # : _______-________-________

Do you have health insurance? _______Name of Insurance Co. ______________________________

ID # __________________ Group # __________________ Verification Ph. # ( )______ - _______

Occupation: ____________________________ Employer: ____________________________

Person to notify in event of emergency (Name & Phone): ______________________________

How did you hear about our office? ____

Does anything limit you from pursuing care? ☐ Y ☐ N If yes, explain:______________________

Other physicians/therapists seen for this condition: ______________________________________

Medications (if any): ______________________________ __________ ________________

____

Treatment: ____

____

____

Results: ____

____

Supplements: (vitamins, herbs, minerals, etc.): ______________________________________

____

____

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal	
1.	☐	☐	☐	☐	___
2.	☐	☐	☐	☐	___
3.	☐	☐	☐	☐	___
4.	☐	☐	☐	☐	___
5.	☐	☐	☐	☐	___
6.	☐	☐	☐	☐	___
7.	☐	☐	☐	☐	___
8.	☐	☐	☐	☐	___
9.	☐	☐	☐	☐	___

____

How do these conditions impair your daily activities?___________________________

____

II. Patient Medical History

How was your childhood health?____

Hospital Visits/Stays:____

Recent tests: (please indicate test results and date below)

☐ Physical	☐ Cholesterol	☐ Prostate	☐ Blood
☐ HIV/STD	☐ Pap smear	☐ Mammography	☐ Other:____________

Test Results and Date:____

Check any you have had in the past:

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic Fever
☐ Heart Disease	☐ CVA (stroke)	☐ Vein condition	☐ Thyroid disorder
☐ Asthma	☐ Pneumonia	☐ Tuberculosis	☐ Emphysema
☐ Jaundice	☐ Gonorrhea	☐ Mumps	☐ Bleeding tendency
☐ Syphilis	☐ Measles	☐ Chicken pox	☐ Nervous disorder
☐ Meningitis	☐ HIV	☐ Polio	☐ Mononucleosis
☐ Epilepsy	☐ High fever	☐ Hepatitis	☐ Multiple Sclerosis
☐ Paralysis	☐ Cancer	☐ Migraines	☐ High blood pressure
☐ other lung illnesses	☐ other liver illnesses	☐ other heart illnesses	☐ other kidney illnesses
☐ other spleen illnesses	☐ other stomach illnesses	☐ other:____________________	

Immunizations:____

Surgeries and dates:____

____

____

III. Family History

Family Member	Alive	Deceased	Present health or cause of death
Father	☐	☐	______________________________
Mother	☐	☐	______________________________
Spouse	☐	☐	______________________________
Child	☐	☐	______________________________
Brother	☐	☐	______________________________
Brother	☐	☐	______________________________
Brother	☐	☐	______________________________
Sister	☐	☐	______________________________
Sister	☐	☐	______________________________
Sister	☐	☐	______________________________

Where are you in the birth order? ☐ first ☐ last ☐ middle ☐ only

Check any of the following that have occurred in your blood relatives:

☐ Diabetes	☐ Cancer	☐ Heart disease	☐ High blood pressure
☐ Allergies	☐ Tuberculosis	☐ Obesity	☐ Bleeding tendency
☐ Kidney disease	☐ Alcoholism	☐ Nervous illness	☐ Mental illness
☐ Stroke	☐ Other ___________	☐ Other _____________	☐ Other ____________

IV. Patient profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:

☐ Sharp ☐ Burning ☐ Aching

☐ Cramping ☐ Dull ☐ Moving

☐ Fixed ☐ Other:________________

Do the following lessen the pain?

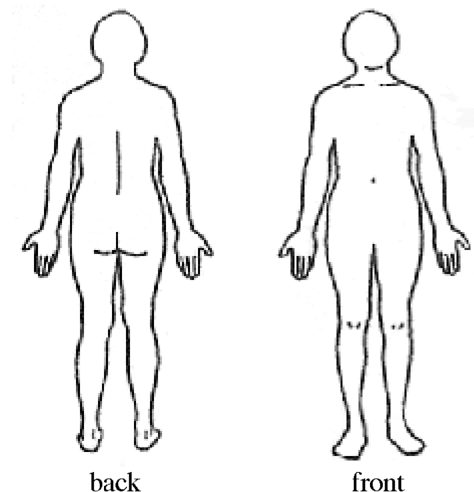
☐ Pressure ☐ Cold ☐ Heat

☐ Exercise ☐ Other:____________________

Do the following worsen the pain?

☐ Pressure ☐ Cold ☐ Heat

☐ Other:___________________________



Please check the following that currently pertain to you:
(If you have symptoms in the following categories, it indicates that you have a problem with that organ's function)

Overall Temperature (Kidney function):

- [ ] Cold hands
- [ ] Cold fingers
- [ ] Cold feet
- [ ] Cold toes
- [ ] Cold body temperature
- [ ] Hot body temperature
- [ ] Sweaty hands
- [ ] Sweaty hands
- [ ] Sweaty feet
- [ ] Afternoon flushes
- [ ] Night sweats
- [ ] Take water to bed
- [ ] Perspire easily
- [ ] Lack of perspiration
- [ ] Thirsty
- [ ] Hot flashes any time of day
- [ ] Heat in the hands, feet, and chest

Overall Energy (Lung, Kidney function):

- [ ] Shortness of breath
- [ ] General weakness
- [ ] Easily catch colds
- [ ] Low energy
- [ ] Difficulty keeping eyes open in the daytime
- [ ] Feel worse after exercise

Overall Blood (Liver, Spleen, Heart function):

- [ ] Dizziness
- [ ] See floating black spots

Heart function:

- [ ] Palpitations
- [ ] Anxiety
- [ ] Restlessness
- [ ] Mental confusion
- [ ] Frequent dreams
- [ ] Wake unrefreshed
- [ ] Chest pain traveling to shoulder
- [ ] Sores on the tip of the tongue
- [ ] Drink coffee (# of cups per week: _______)

Lung function:

- [ ] Nasal Discharge (Color: _________________)
- [ ] Cough
- [ ] Nose Bleeds
- [ ] Sinus Congestion
- [ ] Dry throat
- [ ] Dry Nose
- [ ] Alternating fever and chills
- [ ] Sneezing
- [ ] Stiff neck
- [ ] Overall achy feeling in the body
- [ ] Sore throat
- [ ] Difficulty breathing
- [ ] Smoke cigarettes (# cigarettes per day: _____)
- [ ] Sadness
- [ ] Melancholy
- [ ] Allergies (To what? ____)
- [ ] Dry Skin
- [ ] Headache (Location: ___________________)
- [ ] Dry Skin
- [ ] Stiff Shoulders

Spleen function:

- [ ] Low appetite
- [ ] Abrupt weight gain
- [ ] Abrupt weight loss
- [ ] Abdominal bloating
- [ ] Abdominal gas
- [ ] Fatigue after eating
- [ ] Worry
- [ ] Gurgling noise in stomach
- [ ] Easily bruised
- [ ] Hemorrhoids
- [ ] Pensive
- [ ] Over thinking
- [ ] Prolapsed organs (previously diagnosed, organ) ____)

Spleen, Stomach, Large Intestine, Small Intestine function:

- [ ] Loose
- [ ] Constipated
- [ ] Incomplete
- [ ] Diarrhea
- [ ] Blood in stools
- [ ] Mucous in stools
- [ ] Undigested food in stools

Dampness trapped in the body:

- ☐ General sensation of heaviness in the body
- ☐ Mental heaviness
- ☐ Mental sluggishness
- ☐ Mental fogginess
- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Swollen joints
- ☐ Chest congestion
- ☐ Nausea
- ☐ Snoring

Stomach function:

- ☐ Large appetite
- ☐ Bad breath
- ☐ Stomach pain
- ☐ Hiccups
- ☐ Canker sores
- ☐ Vomiting
- ☐ Ulcer (diagnosed)
- ☐ Belching
- ☐ Heartburn
- ☐ Acid regurgitation
- ☐ Bleeding, swollen or painful gums
- ☐ Burning sensation after eating

Liver and Gall Bladder function:

- ☐ Alternating diarrhea and constipation
- ☐ Chest pain
- ☐ Tight sensation in the chest
- ☐ Bitter taste in the mouth
- ☐ Anger easily
- ☐ Frustration
- ☐ Depression
- ☐ Irritability
- ☐ Skin rashes
- ☐ Tingling sensation
- ☐ Frequently unable to adapt to stress (What causes the stress? ___________________________________)
- ☐ Headache at the top of the head
- ☐ Numbness
- ☐ Muscle spasms
- ☐ Muscle twitching
- ☐ Muscle cramping
- ☐ Seizures
- ☐ Convulsions
- ☐ Lump in the throat
- ☐ Neck tension
- ☐ Limited Range-of-Motion, Neck
- ☐ Shoulder tension
- ☐ Limited Range-of-Motion, Shoulder
- ☐ Gall stones (history or current)
- ☐ Recreational drugs (Which? _______________________________________How much per week? ________)
- ☐ High-pitched ringing in the ears
- ☐ Drink alcohol (How much per week? ______________)
- ☐ Sexually transmitted disease (Which? ____)

Eyes (Liver function):

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Near-sighted
- ☐ Far-sighted

Kidney, Urinary Bladder function:

- ☐ Frequent cavities
- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weak knees
- ☐ Low back pain
- ☐ Memory problems
- ☐ Kidney stones
- ☐ Cold sensation in the knees
- ☐ Excessive hair loss
- ☐ Fear
- ☐ Easily startled
- ☐ Lack of bladder control
- ☐ Low-pitched ringing in the ears
- ☐ Bladder infections
- ☐ Early graying of hair
- ☐ Wake during the night twice or more to urinate

Libido/Sexual energy:

- ☐ Normal
- ☐ High
- ☐ Low

Urination:

☐ Normal color ☐ Dark yellow ☐ Clear ☐ Reddish
☐ Cloudy ☐ Scanty ☐ Profuse ☐ Strong odor
☐ Burning ☐ Painful ☐ Discharge ☐ Difficult
☐ Painful ☐ Urgent ☐ Frequent ☐ Dribbling

Women only:

Pregnant? ☐ Y ☐ N Number of pregnancies: _____ Number of children:____

Regular menstrual cycle? ☐ Y ☐ N Age of first menstruation:_____ Average number of days of flow:____

Average number of days of entire cycle:______ ☐ Vaginal discharge ☐ Bleeding between periods

Age of menopause (if applicable): ____ Did/do you experience any symptoms during perimenopause (eg. hot flashes, insomnia, night sweats, depression, irritability, fatigue, etc)? If yes, describe: _______________________

____

Do you experience any of the following **pre**menstrual symptoms? Check all that apply.

☐ nausea ☐ vomiting ☐ water retention ☐ breast swelling
☐ food cravings ☐ headaches ☐ migraines ☐ breast tenderness
☐ depression ☐ irritability ☐ anxiety ☐ other emotions:____________
☐ dull pain, where?__________________ ☐ sharp pain, where?____________________

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other:							

Men Only:	Severe	Moderate	Slight	Normal
☐ Swollen testes	☐	☐	☐	☐
☐ Testicular pain	☐	☐	☐	☐
☐ Impotence	☐	☐	☐	☐
☐ Premature ejaculation	☐	☐	☐	☐
☐ Feeling of coldness or numbness in external genitalia	☐	☐	☐	☐
☐ Other________________	☐	☐	☐	☐