

PACIFIC NUTRITION AND WELLNESS

Date: ___/___/___			
HEALTH HISTORY QUESTIONNAIRE			
All questions contained in this questionnaire are strictly confidential and will become part of your medical record.			
Name: <i>(Last, First, M.I.)</i>		M F	DOB: ___/___/___
PRESENT HEALTH CONCERN(S)			
Please describe your current problem(s) and why you are seeking consultation.			
ILLNESSES (Check all that apply)			
Have you ever been diagnosed with any of the following illnesses or medical problems? If yes, include approximate date or year.			
High Blood Pressure	Date/Yr:	Asthma/Bronchitis	Date/Yr:
Coronary Artery Disease	Date/Yr:	Emphysema	Date/Yr:
Heart Attack	Date/Yr:	Multiple Sclerosis	Date/Yr:
Angina	Date/Yr:	Parkinson's Disease	Date/Yr:
Heart Failure	Date/Yr:	Alzheimer's Disease	Date/Yr:
GERD – Acid Reflux	Date/Yr:	Multiple Sclerosis	Date/Yr:
Heart Attack	Date/Yr:	Seizures	Date/Yr:
Angina	Date/Yr:	Thyroid Disease	Date/Yr:
Cerebrovascular Accident (Stroke)	Date/Yr:	Diabetes	Date/Yr:
Diverticulosis/Diverticulitis	Date/Yr:	Hiatal Hernia	Date/Yr:
Gout	Date/Yr:	Glaucoma	Date/Yr:
Depression	Date/Yr:	HIV/AIDS	Date/Yr:
Cardiac Arrhythmia	Date/Yr:	Transient Ischemic Attack (TIA)	Date/Yr:
Heart Murmur	Date/Yr:	Deep Venous Thrombosis	Date/Yr:
Abdominal Aortic Aneurysm	Date/Yr:	Genital Herpes	Date/Yr:
Pulmonary Tuberculosis	Date/Yr:	Hepatitis	Date/Yr:
Genital Condyloma	Date/Yr:	Cholelithiasis	Date/Yr:
Padget's Disease	Date/Yr:	Ulcerative Colitis	Date/Yr:
Anemia	Date/Yr:	Osteoarthritis	Date/Yr:
Leukemia	Date/Yr:	Colon Cancer	Date/Yr:
Cervical Cancer	Date/Yr:	Cystocele/Rectocele	Date/Yr:
Ovarian Cancer	Date/Yr:	Hodgkin's Disease	Date/Yr:
Breast Cancer	Date/Yr:	Malignant Lymphoma	Date/Yr:
Bladder Cancer	Date/Yr:	Lung Cancer	Date/Yr:
Prostate Cancer	Date/Yr:	Kidney Cancer	Date/Yr:
Testis Cancer	Date/Yr:	Penile Cancer	Date/Yr:
Kidney Stones	Date/Yr:		Date/Yr:
Urinary Incontinence	Date/Yr:	Urinary Tract Infection	Date/Yr:
Prostate Enlargement (BPH)	Date/Yr:	Prostatitis	Date/Yr:

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Other

Advance Directive	None	Living Will	Surrogate
Alcohol		None	
Beer (drinks/wk): _____	Duration: _____ years	Date Discontinued: _____	
Wine (drinks/wk): _____	Duration: _____ years	Date Discontinued: _____	
Liquor (drinks/wk) : _____	Duration: _____ years	Date Discontinued: _____	
Tobacco		None	
Cigarette (pks/day): _____	Duration: _____ years	Date Discontinued: _____	
Cigar (#/day): _____	Duration: _____ years	Date Discontinued: _____	
Pipe (#/day): _____	Duration: _____ years	Date Discontinued: _____	
Chew (#/day): _____	Duration: _____ years	Date Discontinued: _____	
Snuff (#/day): _____	Duration: _____ years	Date Discontinued: _____	
Drugs		None	
Marijuana (#/day): _____	Duration: _____ years	Date Discontinued: _____	
Cocaine (#/day): _____	Duration: _____ years	Date Discontinued: _____	
Other (#/day): _____	Duration: _____ years	Date Discontinued: _____	
FAMILY HEALTH HISTORY			
No History of Familial Disease			
Relative (i.e., Father, Mother, Uncle, Sister, etc.)		Illness (i.e., Diabetes, Heart Disease, Prostate Cancer, etc.)	
REVIEW OF SYSTEMS (Check all that apply)			
General	Anorexia	Chills	Fatigue
Fever	Malaise	Sweats	
Weight Loss			
Eyes	Blurred Vision	Double Vision	Eye Pain
Eye Discharge	Vision Loss	Eye Irritation	
Ears, Nose, and Throat	Decreased Hearing	ringing in Ears	Ear Pain
Hoarseness	Pain with Swallowing	Nose Bleeds	
Cardiovascular	Chest Pain	Peripheral Edema	
Palpitations			
Respiratory	Cough	Wheezing	Bloody Sputum
Shortness of Breath			
Gastrointestinal	Abdominal Pain	Nausea	Vomiting
Diarrhea	Constipation	Tarry Stools	
Bloody Stools			
Genitourinary	Painful Urination	Blood in Urine	Sexual Dysfunction
Difficulty Voiding	Urinary Incontinence		

Musculoskeletal	Back Pain	Joint Pain	Joint Swelling
Muscle Weakness			
Skin	Dryness	Itching	Rash

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Suspicious Lesion		
Neurological	Dizziness	Weakness
Seizures		Tremors
Psychiatric	Depression	Anxiety
Hallucinations		Memory Loss
Endocrine	Cold Intolerance	Heat Intolerance
Weight Change		Increased Thirst
Hematologic and Lymphatic	Abnormal Bruising	Easy Bleeding
Allergic and Immunologic	Hay Fever	Itching
		Enlarged Lymph Nodes
		HIV Exposure
CERTIFICATION		
The above information is true to the best of my knowledge.		
X		
Patient/Legal Guardian/Authorized Person (Signature)		Date of Signature