Essential Wellness Of Illinois, LLC—Health History Questionnaire

Christine A. Renz L.Ac., Dipl OM, MSTOM

Name_____ Date_____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell_____ Fax _____ Email_____

Emergency Contact _____ Emergency Number_____

Date of Birth_____ Age _____ Sex_____ Height _____Weight _____Lbs Marital Status_____

Occupation_____ Who referred you to this office? _____

Name of Physician_____ Physician's Contact Info_____

1. What is the main health problem for which you are seeking treatment?

_____

2. When did the problem begin and what symptoms did you notice? Please be specific_____

_____

_____

3. To what extent does the problem interfere with your daily activity?_____

_____

4. Have you been given a medical diagnosis for the problem? If so, what?_____

_____

5. What other forms of treatment have you sought and/or are currently undergoing? _____

_____

6. List any other health problems you have now:_____

_____

Past Medical History – please note dates:

Cancer: _____ HIV/AIDS: _____ Thyroid Disease: _____

Diabetes: _____ High BP: _____ Rheumatic Fever: _____

Hepatitis (A/B/C): _____ Heart Disease: _____ Venereal Disease: _____

Other Medical Diagnoses: _____

Surgeries (types & dates): _____

_____

Significant Traumas: _____

_____

Significant Dental Work: _____

_____

Allergies (drugs, chemicals, foods, etc.): _____

_____

Occupational Stress (chemical, physical, psychological): _____

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Family Medical History (Significant illnesses by a blood relative)

☐ Cancer	☐ Heart Disease	☐ Thyroid Problems
☐ Asthma	☐ Glaucoma	☐ Tuberculosis
☐ Diabetes	☐ Stroke	☐ Migraines
☐ High Blood Pressure	☐ Seizures	☐ Other _____
☐ Allergies	☐ Emotional Difficulties	

Medications

What medications or supplements are you currently taking?

Medication	Dose	How long have you been taking it?

Have you had any courses of antibiotics recently? ☐ Many ☐ A few ☐ 1 or 2 ☐ None

Habits

What kind of physical activity level (exercise, sports) do you participate in?_____

How often per week? _____How long each time? _____

Are you or have you been on a restricted diet? What kind and why?_____

_____

Please indicate usage per day or per week:

Cigarettes	_____ per _____	Tea	_____ per _____
Alcohol	_____ per _____	Soft Drinks	_____ per _____
Drugs	_____ per _____	Sugar	_____ per _____
Coffee	_____ per _____	Other	_____ per _____

What do you typically eat for:
Breakfast: _____

Lunch: _____

Dinner: _____

How much water do you drink per day?_____

Do you suffer from any of the following?
Check all that apply to you within the last twelve months.

- ☐ Night sweats
- ☐ Bleed or bruise easily
- ☐ Fevers
- ☐ Fatigue
- ☐ Anemia
- ☐ Sudden energy drops
  Time of day? _____
- ☐ Edema

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Nightmares

- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Muscle spasms
- ☐ Back pain (lower)
- ☐ Back pain (middle)
- ☐ Back pain (upper)
- ☐ Pain goes down the legs
- ☐ Joint/bone pain
  Where_____
- ☐ Neck pain
- ☐ Knee pain
- ☐ Shoulder pain
- ☐ Hand pain
- ☐ Foot pain
- ☐ Torn tissues
- ☐ Numbness
  Where_____

- ☐ Cough
- ☐ Cough with blood
- ☐ Shortness of breath
- ☐ Pain with breathing
- ☐ Bronchitis
- ☐ Seasonal allergies
- ☐ Frequent colds
- ☐ Pneumonia
- ☐ Production of phlegm
  Color of phlegm_____
- ☐ Asthma
- ☐ Lack of perspiration
- ☐ Excessive perspiration

- ☐ Nasal or sinus congestion
- ☐ Sinus infections
- ☐ Loss of smell
- ☐ Nose bleeds
- ☐ Nasal polyps

- ☐ Irregular heartbeat
- ☐ Poor circulation
- ☐ Dizziness
- ☐ Heart Palpitations
- ☐ Fainting spells
- ☐ Chest pains
- ☐ Heart attack

- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Swelling of hands or feet
- ☐ Blood clots

- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting with blood
- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Abdominal cramping or pain
- ☐ Acid regurgitation
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Diarrhea
- ☐ Constipation
- ☐ Laxative use
- ☐ Alternating constipation and diarrhea
- ☐ Hemorrhoids
- ☐ Rectal pain
- ☐ Burning sensation in anus
- ☐ Strong smelling stools
- ☐ Blood in stools
- ☐ Pain with passing stool
  Bowel movements every_____day
  _____number of bowel movements/day

- ☐ Frequent urination
- ☐ Excessive urination
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Burning on urination
- ☐ Difficulty urinating
- ☐ Decreased in urinary flow
- ☐ Incontinence at night
- ☐ Dribbling urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Sexually transmitted diseases
- ☐ Prostate problems
- ☐ Impotency
- ☐ Changes in sexual drive
- ☐ Rashes
  Do you wake at night to urinate?
  If yes, how many times?_____

- Wear glasses
- Blurred vision
- Double vision
- Cataracts
- Glaucoma
- Eyes feel swollen
- Pressure in the eye
- Eye pain
- Eye tiredness/strain
- Seeing spots/floaters
- Sensitivity to light
- Eye dryness
- Eye redness
- Eye itchiness
- Eye tearing

- Hearing difficulties
- Ringing in the ears
- Ear pain
- Discharge from ear
- Loss of balance
- Ear infections

- Sore throats
- Hoarseness
- Tonsillitis
- Swollen glands
- Mouth dryness
- Bad taste in mouth
- Bad breath
- Mouth or lip sores/ulcerations
- Sore gums
- Bleeding gums
- Sore tongue
- Numbness in the tongue
- Grinding teeth
- Teeth problems

- Changes in skin color
- Skin bruising
- Dry skin
- Dandruff
- Eczema
- Skin rashes
- Skin acne
- Body hair/skin changes
- Psoriasis
- Skin ulcerations
- Itching skin
- Oozing sores
- Recent moles

- Sudden weight loss
- Sudden weight gain
- Diabetes
- Thyroid disorders

- Anxiety
- Panic attacks
- Depression
- Irritability
- Hot tempered
- Easily susceptible to stress
- Lose control of emotions
- Fear
- Problems with alcohol or drug use
- Psychoactive medications
  If yes, which ones?_____
- Emotional difficulties
- Anorexia
- Bulimia

  Have you ever been treated for emotional problems?_____

  Have you ever considered or attempted suicide?_____

- Seizures
- Concussion
- Headaches
- Shaking/tremors
- Cysts/tumors
- Nerve damage
- Paralysis
- Stroke
- Vertigo
- Poor memory
- Difficulty concentrating

- Fevers
- Chills
- Cold intolerances
- General chilliness
- Cold hands/feet
- Heat intolerance
- General warmth
- Strong thirst (hot or cold)

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Female Patients: Please fill the following section

Pregnancy: Are you presently pregnant? Y N Not sure
Please list history of pregnancy, note if full term (FT), premature (P), miscarriage (MC), abortions (A), whether vaginal (V) or Cesarean section (C). Note any difficulties you experienced during the pregnancy and/or after delivery (for example morning sickness, edema, prolonged bleeding after delivery, gestational diabetes, high blood pressure, fever postpartum etc.)
Year

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____

Menstruation
Age of onset _____ Last Menstrual Period (first day of) _____ Date of last Pap exam ___/___/__
Result _____ Length between periods _____
Regularity:
□ regular □ irregular □ usually early by ____days □ usually late by ____ days □ varies between being early or late
How many days of menstrual flow do you usually have? _____

Flow is: □ even □ uneven □ heavy □ light
Color is: □ pale □ pink □ light red □ red □ deep red □ purplish □ brown
Consistency is: □ thin □ thick □ clotted

Discomfort with period:
□ lower abdominal distention □ before □ during □ after menstruation
□ lower back soreness □ before □ during □ after menstruation
□ cramping □ before □ during □ after menstruation
□ Other_____

Premenstrual Syndrome (PMS)
□ irritability □ bloating □ mood swings □ breast tenderness
□ other _____

Vaginal Discharge
□ No □Yes If yes, color and amount:_____

Menopause:
Age of onset _____ Any difficulties / symptoms? _____

Uterine bleeding (not related to periods) Color _____ amount _____
□ comes on suddenly □ all the time