

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)

- | | | |
|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emotional Difficulties | |

Medications

What medications or supplements are you currently taking?

<u>Medication</u>	<u>Dose</u>	<u>How long have you been taking it?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.

- | | |
|---|--|
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Sudden energy drops |
| <input type="checkbox"/> Fevers | Time of day? _____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Edema |

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- 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?_____

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- 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