Virginia Natural Health

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your personal record.

Name (Last, First, M.I.):		☐ M ☐ F	**Birth Date:**
Preferred Name:		**Marital status:**	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Previous or referring doctor:		**Date of last physical exam:**	

Please List Your Chief Medical Concerns:

PERSONAL HEALTH HISTORY		
List any medical problems that other doctors have diagnosed, and date of onset or diagnosis		
Surgeries		
Year	Reason	Outcome?
Other hospitalizations		
Year	Reason	Outcome?

Have you ever had a blood transfusion?	☐ Yes	☐ No

Virginia Natural Health 1561 Commerce Rd. (Route 11), Suite 402, Verona, VA 24482 (540.416.0530)

List your prescribed drugs, over-the-counter drugs, such as vitamins and inhalers, and recreational drugs. Use page 7 if needed.				
Name of Drug/Name and Brand of Supplement	Dosage	Frequency	Date Started	Reason for taking

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY						
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	□ Sedentary (No exercise)					
	□ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	□ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	□ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				Yes	No
	If yes, are you on a physician prescribed medical diet?				Yes	No
	# of meals you eat in an average day?					
	Rank salt intake	□ Hi	□ Med	□ Low		
	Rank fat intake	□ Hi	□ Med	□ Low		
Caffeine	□ None	□ Coffee	□ Tea	□ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				□ Yes	□ No
	If yes, what kind?					

	How many drinks per week?									
	Are you concerned about the amount you drink?								☐ Yes	☐ No
	Have you considered stopping?								☐ Yes	☐ No
	Have you ever experienced blackouts?								☐ Yes	☐ No
	Are you prone to "binge" drinking?								☐ Yes	☐ No
	Do you drive after drinking?								☐ Yes	☐ No
Tobacco	Do you currently use tobacco?	☐	Yes	☐	No		History of Tobacco Use?		☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day				☐ Pipe - #/day		☐ Cigars - #/day	
	# of years:	Year quit:								
Drugs	Use of recreational or street drugs: ☐ Only in past ☐ Currently ☐ Never									
	Have you ever given yourself street drugs with a needle?								☐ Yes	☐ No
Sex	Are you sexually active? ☐ Yes ☐ No Gender of Partner(s): M F Number of partners in last two years:									
	If yes, are you trying for a pregnancy?								☐ Yes	☐ No
	If not trying for a pregnancy, please list contraceptive or barrier method used:									
	Any discomfort with intercourse?								☐ Yes	☐ No
Personal Safety	Do you live alone?								☐ Yes	☐ No
	Do you have frequent falls?								☐ Yes	☐ No
	Do you have vision or hearing loss?								☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?								☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?								☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	□ M □ F	
Mother				□ M □ F	
Sibling	□ m □ F			□ M □ F	
	□ M □ F			□ M □ F	
	□ M □ F		**Grandmothe** Maternal		
	□ M □ F		**Grandfather** Maternal		
	□ M □ F		**Grandmothe** Paternal		
	□ M □ F		**Grandfather** Paternal		

MENTAL HEALTH

Is stress a major problem for you?	□ Yes	□ No
Do you feel depressed?	□ Yes	□ No
Do you panic when stressed?	□ Yes	□ No
Do you have problems with eating or your appetite?	□ Yes	□ No
Do you cry frequently?	□ Yes	□ No
Have you ever attempted suicide?	□ Yes	□ No
Have you ever seriously thought about hurting yourself?	□ Yes	□ No
Do you have trouble sleeping?	□ Yes	□ No
Have you ever been to a counselor?	□ Yes	□ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and bimanual exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree. Briefly explain.

☐	Skin	☐	Chest/Heart		Recent changes in:
☐	Head/Neck	☐	Back	☐	Weight
☐	Ears	☐	Intestinal	☐	Energy level
☐	Nose	☐	Bladder	☐	Ability to sleep
☐	Throat	☐	Bowel	☐	Other pain/discomfort:
☐	Lungs	☐	Circulation		

Toxic Exposures

Please list current and former occupations:

Have you had any known exposure to volatile chemicals, heavy metals, pesticide? Dates?
Please explain:

List any allergies. Date of onset. Are they seasonal or persistent? Please explain

Is there mold in your home?

Have you lived near factories, electrical power substations or trunk lines, incinerators, golf courses, farms or known hazardous chemical dumps? Please Explain:

Have you worked in the farming industry? Chemical based or organic?

Energy Level	
Please rate your energy level on a scale of 1 to 10: 10 = vibrant and highly energetic, 1 = can hardly get out of bed	1 2 3 4 5 6 7 8 9 10
Is your energy relatively even over the day, or does it vary significantly?	
Do you have problems concentrating or finishing tasks?	□ Yes □ No
Do you have cravings for certain foods? If so, please list foods and <u>when</u> during the day you crave them.	□ Yes □ No
Do you wake up refreshed? How many hours of sleep do you average per night: How many hours of naps do you average per day:	□ Yes □ No
What do you do for relaxation/recreation?	

Please tell us anything else that you feel we should know in order to give you the very highest level of medical advice: