Medical History and Present Medical Condition Questionnaire

NAME ..... DATE .....

Health conditions

Do you currently have or have you recently had any of the following? Check all that apply.

Ear, nose, and throat

- ◯ Allergies
- ◯ Hearing loss
- ◯ Frequent nosebleeds
- ◯ Frequent sinus trouble
- ◯ Frequent hoarseness
- ◯ Ringing/buzzing ears
- ◯ Earaches
- ◯ Other ear, nose, throat conditions: .....

Eyes and vision

- ◯ Poor night vision
- ◯ Change in vision
- ◯ Blurred or double vision
- ◯ Glaucoma
- ◯ Other eye / vision conditions: .....

Neurological and cognitive

- ◯ Epilepsy
- ◯ Convulsions/seizures
- ◯ Anxiety
- ◯ Depression
- ◯ Mood disorder
- ◯ Trouble thinking and / or remembering
- ◯ Dizziness
- ◯ Frequent headaches
- ◯ Tremors
- ◯ Memory loss
- ◯ Loss of coordination
- ◯ Difficulty concentrating
- ◯ Numbness / tingling extremities
- ◯ Other mental health conditions: .....
- ◯ Other neurological/cognitive conditions: .....

Mouth and oral health

- ◯ Bleeding gums and / or sore mouth
- ◯ Tooth decay
- ◯ Bad breath
- ◯ Other mouth / oral health conditions: .....

Lungs and airway

- ◯ Asthma
- ◯ Shortness of breath
- ◯ Chronic or frequent cough
- ◯ Brown/blood-tinged sputum
- ◯ Chest tightness
- ◯ Wheezing
- ◯ Other lung / airway conditions: .....

Heart and circulation

- ◯ Fainting or lightheadedness
- ◯ Heart attack
- ◯ Heart murmur
- ◯ Positive stress test
- ◯ Heart valve abnormality
- ◯ Angina
- ◯ Heart failure
- ◯ High blood pressure
- ◯ Palpitation (irregular heartbeat)
- ◯ Pain or discomfort in chest
- ◯ High cholesterol
- ◯ Stroke
- ◯ Swelling of feet
- ◯ Leg pain while walking
- ◯ Painful varicose veins
- ◯ Bleeding / bruising easily
- ◯ Anemia
- ◯ Other heart / circulation conditions:

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Skin

- ◯ Eczema
- ◯ Psoriasis
- ◯ Acne
- ◯ Skin cancer
- ◯ Fungal infections
- ◯ Other skin-related conditions:

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Sleep

- ◯ Sleep apnea
- ◯ Snoring
- ◯ Insomnia
- ◯ Other sleep-related conditions:

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Genito-urinary

- ◯ Kidney disease
- ◯ Prostatitis
- ◯ Urinary tract infection
- ◯ Difficulty starting/stopping urination
- ◯ Urinating 2 or more times per night
- ◯ Frequent or painful urination
- ◯ Other genito-urinary conditions:

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Gastrointestinal

- ◯ Trouble swallowing
- ◯ GERD/heartburn
- ◯ Frequent indigestion
- ◯ Ulcer
- ◯ Vomited blood
- ◯ Hepatitis
- ◯ Liver disease
- ◯ Elevated liver enzyme test
- ◯ Hernia
- ◯ Bloating and / or gas
- ◯ Crohn's / Colitis / IBD
- ◯ Persistent diarrhea
- ◯ Persistent constipation
- ◯ Frequent abdominal pain
- ◯ Frequent nausea
- ◯ Black/bloody bowel movement
- ◯ Hemorrhoids
- ◯ Known food allergies (causing anaphylaxis or hives):

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- ◯ Known food intolerances:

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- ◯ Other gastrointestinal conditions:

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Hormones

- ○ Thyroid conditions
- ○ Diabetes
- ○ Trouble controlling blood sugar
- ○ Sex hormone imbalance
- ○ Low or high cortisol
- ○ Other hormonal conditions:

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Musculoskeletal

- ○ Back trouble/pain
- ○ Neck trouble/pain
- ○ Joint injury/pain/swelling
- ○ Carpal tunnel syndrome
- ○ Other musculoskeletal conditions:

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Immune & autoimmune

- ○ Swollen glands
- ○ Rheumatoid arthritis
- ○ Lupus
- ○ Chronic fatigue syndrome
- ○ Other immune/ autoimmune conditions:

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Miscellaneous

- ○ Cancer
- ○ Undesired weight loss

Men's health

- ○ Prostatitis
- ○ Low testosterone
- ○ Infertility
- ○ Trouble with sexual function
- ○ Other men's health conditions:

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Women's health

- ○ PCOS
- ○ Infertility
- ○ Endometriosis
- ○ Painful menstruation
- ○ PMS
- ○ Hot flashes / night sweats
- ○ Trouble with sexual function
- ○ Other women's health conditions:

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Are you:

- ○ Trying to conceive?
- ○ Currently pregnant?
- ○ Post-partum (up to 1 year)?
- ○ Breastfeeding?

Should you normally be menstruating regularly? (Y) (N)

If so, are you getting a regular period? (Y) (N)

If no, are you: ○ Peri-menopausal ○ Menopausal

Have you had a Pap smear in the last 5 years? (Y) (N)

Are you on hormone replacement or hormonal birth control? If yes, what? Y N

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How often do you visit the doctor for a check-up?

- ○ Monthly or more
- ○ Every few months
- ○ Once or twice a year
- ○ Every 2-5 years
- ○ What's a doctor and why would I visit one?

Are you currently under a doctor's care? If yes, for what? Y N

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Have you had any surgeries and / or been hospitalized in the last 10 years? If yes, what? Y N

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Are there any other significant health concerns that I haven't asked about? If so, please tell me about them.

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Are you experiencing any stresses, mood conditions, relationship difficulties, or substance-related conditions for which you would like resources or a confidential referral? If so, please describe briefly. Y N

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Medication, drug, and supplement use

Do you take any over-the-counter or prescription medications occasionally or regularly? Y N

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Are you on hormone replacement / supplementation, or hormonal birth control?
(e.g., testosterone, estrogen, birth control pill, Nuva Ring) If yes, what? Y N

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Do you take any sports supplements or "natural" health products occasionally or regularly?
(e.g., creatine, BCAAs, gingko, ginseng, St. John's Wort) If yes, what? Y N

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Do you take any other vitamin or mineral supplements occasionally or regularly?
(e.g., multivitamin, iron supplement) If yes, what? Y N

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How often do you consume alcohol?

- ○ I don't drink alcohol at all
- ○ About once every 2 weeks
- ○ More than once a week
- ○ About once a month or fewer
- ○ About once a week
- ○ Daily

Each time you consume alcohol, how many drinks do you have (one drink = 12 ounces of beer, 5 ounces wine, 1.5 ounces hard liquor)?

- ○ I don't drink alcohol at all
- ○ 2-3 drinks
- ○ More than 3 drinks
- ○ 1 drink

How often do you use recreational drugs?

- ○ I don't at all
- ○ About once every 2 weeks
- ○ More than once a week
- ○ About once a month or fewer
- ○ About once a week
- ○ Daily

Do you smoke? If yes, how many packs a day? Y N

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Did you smoke in the past? If yes, when did you quit? Y N

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Further information

If you ticked off any health issues in the "Health conditions" section, please give more details.

HEALTH CONDITION	DETAILS
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