



# Virginia Natural Health

## HEALTH HISTORY QUESTIONNAIRE

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

<b>Name</b> (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	<b>Birth Date:</b>
<b>Preferred Name:</b>	<b>Marital status:</b>		<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
<b>Previous or referring doctor:</b>		<b>Date of last physical exam:</b>	

**Please List Your Chief Medical Concerns:**

### PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed, and date of onset or diagnosis

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#### Surgeries

Year	Reason	Outcome?

#### Other hospitalizations

Year	Reason	Outcome?

<b>Have you ever had a blood transfusion?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**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.

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
<b>Diet</b>	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med <input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med <input type="checkbox"/> Low
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Cola
	# of cups/cans per day?		
<b>Alcohol</b>	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?		

How many drinks per week?										
Are you concerned about the amount you drink?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you considered stopping?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever experienced blackouts?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you prone to "binge" drinking?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you drive after drinking?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Tobacco</b>	Do you currently use tobacco?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of Tobacco Use?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="checkbox"/> Cigarettes – pks./day		<input type="checkbox"/> Chew - #/day			<input type="checkbox"/> Pipe - #/day		<input type="checkbox"/> Cigars - #/day		
	# of years:	Year quit:								
<b>Drugs</b>	Use of recreational or street drugs: <input type="checkbox"/> Only in past <input type="checkbox"/> Currently <input type="checkbox"/> Never									
	Have you ever given yourself street drugs with a needle?								<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Sex</b>	Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No Gender of Partner(s): M F Number of partners in last two years:									
	If yes, are you trying for a pregnancy?								<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy, please list contraceptive or barrier method used:									
	Any discomfort with intercourse?								<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Personal Safety</b>	Do you live alone?								<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?								<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?								<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?								<input type="checkbox"/> Yes	<input type="checkbox"/> 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?								<input type="checkbox"/> Yes	<input type="checkbox"/> No

## FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> m <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> Maternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> Maternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> Paternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> Paternal		

## MENTAL HEALTH

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

**WOMEN ONLY**

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

**MEN ONLY**

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

- |                                    |                                      |   |
|------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Skin      | <input type="checkbox"/> Chest/Heart | Recent changes in:                              |
| <input type="checkbox"/> Head/Neck | <input type="checkbox"/> Back        | <input type="checkbox"/> Weight                 |
| <input type="checkbox"/> Ears      | <input type="checkbox"/> Intestinal  | <input type="checkbox"/> Energy level           |
| <input type="checkbox"/> Nose      | <input type="checkbox"/> Bladder     | <input type="checkbox"/> Ability to sleep       |
| <input type="checkbox"/> Throat    | <input type="checkbox"/> Bowel       | <input type="checkbox"/> Other pain/discomfort: |
| <input type="checkbox"/> Lungs     | <input type="checkbox"/> Circulation |   |

## Toxic Exposures

Please list current and former occupations:

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

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

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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:

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

