Imagine Health
Partners in Wellness
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Health History Questionnaire

Patient Information: Please print	
Date _____	Home Phone _____
Name _____	Work Phone _____
Address _____	Other/Cell _____
City State Zip _____	Email _____
Age ____ Birthdate _____ Sex ___M___F	Emergency Contact Person:
Occupation _____	Name _____
Primary Physician _____	Relationship _____
Physician Phone _____	Home Phone _____
How did you hear about us _____	Other/Cell _____

Health History:	
Reasons for seeking treatment: Top 3 1. _____ When did it start _____ 2. _____ When did it start _____ 3. _____ When did it start _____ Circle family illnesses that have occurred: Diabetes High Blood Pressure Stroke Cancer Heart Disease Kidney Disease How long since your last complete medical exam: _____ Are you pregnant or could you be: ____ Yes ___ No Due Date: _____	List medications/supplements you are taking: _____ _____ List any past injuries/surgeries/traumas: _____ _____ **For Women Only**: Last menstrual cycle _____ Length of cycle _____ Length between each cycle _____ ● Bleeding between periods ● Clots in menses ● Heavy or scanty menstrual flow (circle one) ● Painful menstruation ● Irregular cycle ● Menopausal symptoms ● Previous miscarriage ● PMS

Check all symptoms you have or have had in the last year.

- Depression/Anxiety/Bipolar
- Difficulty in focusing/ADD/ADHD
- Dizziness
- Easily startled
- Excessive worry
- Excessive anger
- Excessive fear
- Fatigue/tiredness
- Headaches/migraines
- Loss of sleep/poor sleep
- Loss or gain of weight (circle one)
- Nervousness/irritability
- Overwhelmed by life
- AIDS
- Allergies
- Anemia
- Arthritis
- Bleeding disorders
- Breast lump
- Cancer
- Diabetes

Cardiovascular

- Chest pain/heart pain
- Hardening of arteries
- High or low blood pressure
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles
- Pacemaker
- Bleeding disorder

Gastrointestinal

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Hemmorhoids
- Indigestion
- Nausea
- Stomach pain
- Poor appetite
- Vomiting

Muscle/Joint/Bones

- Tremors or cramps
- Swollen joints

Pain, weakness, or numbness in:

- Arms or hips
- Back or legs
- Feet
- Neck
- Hands
- Shoulders
- Sciatica

Eyes/Ear/Nose/Throat/Respiratory

- Asthma/wheezing
- Blurred vision or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems
- Jaw clenching/grinding teeth

Skin

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sores won't healt
- Sweats
- Hair loss

Genito/Urinary

- History of urinary tract infections
- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

For Men Only

- Erection difficulties
- Penis discharge
- Prostate trouble
- Infertility

This info is correct to the best of my knowledge	Signature: Date: