New Patient Health Questionnaire for Wellness Services

Name: ______________________________________ Preferred name:____________________ Date:________________________

DOB: _________________________ Age:__________ Home Phone:_________________ Mobile Phone: _______________

Email address: ___________________________________ Receive email announcements/newsletters/updates/offers?* Y N

*(*LHHP will never sell, lease, or otherwise disclose your email address/personal information.)*

Address:____

Emergency Contact Info: __________________________ Relationship: ___________Phone Number:___________________

What medical concerns bring you to our office? ____

Marital Status: *(circle)* S M D W Occupation: *(if retired, previous occupation)*__________________________________

If disabled, check here: Nature of disability ___________________________________ Birthplace:_________________

Do you exercise routinely? *(circle)* No Yes If *Yes*, what exercise/how often?______________________________________

Have you ever smoked? *(circle)* No Yes Cigar Pipe Cigarettes If *Yes*: #cigarettes/day______#yrs.______

If you have never smoked, skip this question: Do you still smoke now? *(circle)* No Yes If *No*, when did you quit? _________

Caffeine: Do you drink *(circle)* caffeinated coffee, teas or sodas regularly? *(circle)* No Yes #/day ___________

Tell us a little about your home environment: *(e.g. live alone, with family, single parent, house, apt., etc.)*_______________

____

Medical Information

Allergies: Are you allergic to any drugs?*(circle)* No Yes Please list: ____

Allergies: Are you allergic to any foods?*(circle)* No Yes Please list: ____

Medications *(list all medications you are taking regularly. Include over the counter, herbal or natural remedies.)*

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

Medical Illnesses or Conditions *(list any chronic conditions which you have been diagnosed to have)*

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

Have you ever had or been diagnosed to have: *(check box by all that apply)*

POTS/Dysautonomia		Heart Disease		Eczema/Psoriasis		Anemia		Depression/Anxiety	
Glaucoma		Heart Murmur		Digestive Disorder		Bleeding Disorders		Frequent Infections	
Asthma		High Blood Pressure		Lyme Disease/Co-Infections		Bone or Joint Disease		Cancer (type)	
Allergies		Pneumonia		Kidney Disease					
Stroke		TB/Lung Disease		Kidney Stone(s)		Chronic Fatigue Syndrome		ADD/ADHD	
Seizures/Epilepsy		SIBO		Diabetes or PreDiabetes		Migraines		Neuropathy	
Heart Attack or Angina		Jaundice or Liver Disease				Chronic EBV/HHV-6		Mold/Biotoxin Illness	
				Thyroid Disease		Detox Problems		AutoImmune Disorder	

Operations:
Please list any surgery and approximate year

Year	Surgery
______	______________________________
______	______________________________
______	______________________________
______	______________________________
______	______________________________
______	______________________________
______	______________________________

Hospitalizations:
Other than operations

Year	Reason	Hospital
______	______________________________	
______	______________________________	
______	______________________________	
______	______________________________	
______	______________________________	
______	______________________________	
______	______________________________	

Family Medical History	Age	Health *(list significant illness)*	Age at Death	If deceased, cause	Comments
Father					
Mother					
Brothers or Sisters					
Spouse					
Children					

Transfusions: Have you ever had a blood or plasma transfusion *(circle)* No Yes

Weight: What is your weight now? _______ One year ago? _______ Maximum? _______ When? ________

Females Only: Are you pregnant, planning a pregnancy or nursing a child? *(circle)* No Yes

Date of last menstrual period?_______________________

Have you previously received any of the following treatments or therapies? (Mark all that apply.) If so, please explain any side effects, or other difficulties, you experienced related to the treatment or therapy.

- ☐ IV Vitamin Therapy: ____
- ☐ IV Chelation Therapy: ____
- ☐ Far-Infrared Sauna Therapy: ____
- ☐ Hyperbaric Oxygen Therapy: ____
- ☐ Massage Therapy: ____
- ☐ Acupuncture: ____
- ☐ Hormone Replacement Therapy: ____
- ☐ Other: ____

New Patient Health Questionnaire

Name: ____ **DOB/ID:** __________________

Systems Review: Please indicate those items that have been a recurrent or a recent significant change.

Yes	No	Constitutional Symptoms
____	____	Good health lately
____	____	Recent significant weight change
____	____	Unusual fatigue or weakness
____	____	Frequent headaches

Yes	No	Eyes
____	____	Change in vision
____	____	Blurred or double vision
____	____	Eye disease or injury
____	____	Wear glasses/contact lenses?

Yes	No	Ears/Nose/Mouth/Throat/Neck
____	____	Do you wear hearing aids?
____	____	Hearing loss or ringing in ears?
____	____	Earaches or drainage?
____	____	Chronic sinus problems or runny nose
____	____	Nose bleeds
____	____	Mouth sores
____	____	Bleeding gums
____	____	Sore throat/hoarseness or voice change
____	____	Lumps or swollen glands in neck
____	____	Difficulty swallowing
____	____	Neck pain or stiffness

Yes	No	Cardiovascular
____	____	Heart trouble
____	____	Chest pain or angina pectoris
____	____	Palpitations
____	____	Shortness of breath with walking or lying flat
____	____	Swelling feet, ankles or hands
____	____	Waking at night with shortness of breath

Yes	No	Respiratory
____	____	Chronic or frequent cough
____	____	Coughing or spitting up blood
____	____	Shortness of breath
____	____	Asthma or recurrent wheezing

Yes	No	Gastrointestinal
____	____	Loss of appetite
____	____	Change in bowel movements
____	____	Nausea or vomiting
____	____	Painful bowel movements or constipation
____	____	Frequent diarrhea
____	____	Rectal bleeding or blood in stool
____	____	Stomach/abdominal pains or heartburn
____	____	Black or tarry stools

Comments: ____

____

____

Yes	No	Genitourinary
____	____	Frequent urination
____	____	Burning or pain on urination
____	____	Blood in urine
____	____	Change in force or strain when urinating
____	____	Incontinence or dribbling of urine
____	____	Sexual difficulties
____	____	Men: Testicular pain
____	____	Women: Painful periods
____	____	Irregular periods
____	____	Recurrent vaginal discharge

Number of pregnancies (including miscarriages):________

_______ # Deliveries _______ #Miscarriages

Method of birth control (if applicable)_________________

Menopausal, since when: ____________________________

Date of last menstrual period:_________________________

Date of last pap smear:_______________________________

Date of last mammogram:_____________________________

Yes	No	Musculoskeletal
____	____	Joint pain(s)
____	____	Joint stiffness/swelling or warmth
____	____	Weakness of muscles or joints
____	____	Muscle pain or recurrent cramps
____	____	Back pain
____	____	Cold hands or feet
____	____	Difficulty in walking

Yes	No	Integumentary (Skin/Breast)
____	____	Rashes or itching
____	____	Change in skin color or moles
____	____	Change in hair or nails
____	____	Varicose veins
____	____	Breast pain
____	____	Breast lump
____	____	Breast discharge or rash

Yes	No	Neurological
____	____	Frequent, recurring or increasing headaches
____	____	Light-headedness or dizziness
____	____	Convulsions, seizures or spasms
____	____	Numbness or tingling sensations
____	____	Tremors
____	____	Paralysis
____	____	Stroke
____	____	Head injury

Yes	No	Psychiatric
____	____	Memory loss or confusion
____	____	Nervousness
____	____	Insomnia
____	____	Depression
		Endocrine
____	____	Glandular or hormone problem
____	____	Heat or cold intolerance
____	____	Excessive skin dryness
____	____	Excessive thirst or urination
____	____	Change in hand or glove size
		Hematologic / Lymphatic
____	____	Slow to heal after cuts or wounds
____	____	Bleeding or bruising tendency
____	____	Recurrent anemia
____	____	Swelling, warmth or tenderness of veins or history of phlebitis

Yes	No	Allergic / Immunologic
____	____	History of skin reaction or other adverse reaction to:____________________
____	____	Penicillin or other antibiotic: describe reaction:____________________
____	____	Morphine, Demerol or other narcotics reaction:____________________
____	____	Novocain or other anesthetics reaction:____________________
____	____	Aspirin or other pain remedies reaction:____________________
____	____	Tetanus antitoxin or other serums
____	____	Iodine, methiolate or other antiseptic
____	____	Other medications:____________________
____	____	Other known food allergies____________________

Comments:____

I certify that the information provided by me on this form is, to the best of my knowledge, accurate and complete. I acknowledge that withholding any medical information may increase the risk of harm from any treatment I receive.

Patient Signature: ______________________________ Reviewed by:______________________________

Date: ______________________________ Date:______________________________

Physician Review: ____

Physician Signature:______________________________ Date: ______________________________