



### Health Status Interview

**Patient Note: This is a confidential record of your medical history. It will not be released except when you have authorized me to do so. Successful health care and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Mark anything that you do not understand with a question mark. Thank you.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F SS # \_\_\_\_\_

Address: \_\_\_\_\_

Hm Phone: \_\_\_\_\_ Wk Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Is it OK to call you at work? Yes / No

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Hours I work per week: \_\_\_\_\_ Retired

Name of Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Spouse or Partner: \_\_\_\_\_

Married  Separated  Divorced  Widowed  Single  Partnership

How did you hear about this clinic? \_\_\_\_\_

List the most important health concerns in order of their significance to you.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Are you currently receiving healthcare anywhere else? Yes / No

If yes, where and from whom? \_\_\_\_\_

\_\_\_\_\_

If no, when and where did you last receive medical or health care? \_\_\_\_\_

\_\_\_\_\_

Do you have any contagious diseases at this time? Yes / No

If yes, what? \_\_\_\_\_

Weight \_\_\_\_\_ Weight 1 year ago \_\_\_\_\_ Maximum Weight \_\_\_\_\_ when? \_\_\_\_\_

Height \_\_\_\_\_ Desired weight \_\_\_\_\_

Date of last physical exam? \_\_\_\_\_

**Personal Habits**

Do you eat three meals per day? YES NO

How many hours of sleep per night? \_\_\_\_\_

Do you wake up feeling rested? YES NO

Do you spend time outside? YES NO

Have a supportive relationship? YES NO

Do you take vacations? YES NO

Had any major traumas? YES NO

Have a history of abuse? YES NO

Do you drink coffee? YES NO

Do you drink black tea? YES NO

Do you drink cola? YES NO

Do you eat sugar? YES NO

Do you go on diets often? YES NO

Do you use Alcohol? YES NO

How often? \_\_\_\_\_

How much? \_\_\_\_\_

Do you use recreational drugs? YES NO

How often? \_\_\_\_\_ What types? \_\_\_\_\_

Religious or spiritual practice? YES NO

Do you enjoy your job? YES NO

Do you sleep well? YES NO

Do you read? YES NO hrs/wk? \_\_\_\_\_

Do you watch TV? YES NO hrs/wk? \_\_\_\_\_

Do you smoke? YES NO packs/wk? \_\_\_\_\_

Smoke previously? YES NO Years? \_\_\_\_\_

packs/wk? \_\_\_\_\_

Do you eat out often? YES NO

Do you eat salt? YES NO

Do you exercise? YES NO

How often and what type? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List the **medications** that you are currently taking, including dosage

Be sure to include things such as: Laxatives, Cortisone, Tranquilizers, Pain Reliever, Appetite suppressants, Thyroid medications, Antacids, Antibiotics, Sleeping pills and Birth Control Pills.

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List all **vitamins, minerals, herbs, and homeopathic remedies** you are currently taking

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### Typical Daily Food Intake

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

If you know your blood type, please tell us: \_\_\_\_\_

### Family Health History

Childhood Illnesses that you have had:

- Scarlet fever     Diphtheria     Rheumatic fever     Mumps  
 Measles     Chicken pox     German Measles

Immunizations that you have had:

- Polio     Pertussis     Tetanus shot     Diphtheria  
 Measles/Mumps/Rubella     Other \_\_\_\_\_



	Self	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)	___	___	___	___	___	___	___
Health (G = good, P = poor)	___	___	___	___	___	___	___
Age at death (if deceased)	___	___	___	___	___	___	___
Cause of death	_____						

X' those that are applicable:

Cancer	___	___	___	___	___	___	___
Diabetes	___	___	___	___	___	___	___
Heart Disease	___	___	___	___	___	___	___
High Blood Pressure	___	___	___	___	___	___	___
Stroke	___	___	___	___	___	___	___
Epilepsy	___	___	___	___	___	___	___
Mental Illness	___	___	___	___	___	___	___
Asthma	___	___	___	___	___	___	___
Hayfever	___	___	___	___	___	___	___
Hives	___	___	___	___	___	___	___
Anemia	___	___	___	___	___	___	___
Kidney disease	___	___	___	___	___	___	___
Glaucoma	___	___	___	___	___	___	___
Tuberculosis	___	___	___	___	___	___	___
Alcoholism	___	___	___	___	___	___	___

### X-Rays and Special Studies

Please list any Electrocardiograms, electroencephalograms, x-rays, CAT scans, MRIs or other studies you have had done. \_\_\_\_\_

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### Hospitalization and Surgeries

Please list any hospitalizations and/or surgeries that you have had: \_\_\_\_\_

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**Allergies**

To any drugs? \_\_\_\_\_

To any foods? \_\_\_\_\_

To any environmental pollens/grasses? \_\_\_\_\_

Other? \_\_\_\_\_

**Endocrine** (Please circle YES- I have this now, NEVER- had, PAST- had in the past.)

Hypothyroid?	YES	NEVER	PAST	Heat or cold intolerance?	YES	NEVER	PAST
Hypoglycemia?	YES	NEVER	PAST	Diabetes?	YES	NEVER	PAST
Excessive thirst?	YES	NEVER	PAST	Excessive hunger?	YES	NEVER	PAST
Fatigue?	YES	NEVER	PAST	Seasonal depression?	YES	NEVER	PAST
Unexplained weight loss?	YES	NEVER	PAST	Easy weight gain?	YES	NEVER	PAST
Poor appetite?	YES	NEVER	PAST				

**Immune**

Slow wound healing?	YES	NEVER	PAST	Reactions to vaccinations?	YES	NEVER	PAST
Chronic fatigue syndrome?	YES	NEVER	PAST	Chronic infections?	YES	NEVER	PAST
Chronically swollen glands?	YES	NEVER	PAST				

**Neurological**

Seizures?	YES	NEVER	PAST	Paralysis?	YES	NEVER	PAST
Muscle weakness?	YES	NEVER	PAST	Numbness or tingling?	YES	NEVER	PAST
Loss of memory?	YES	NEVER	PAST	Easily stressed?	YES	NEVER	PAST
Vertigo?	YES	NEVER	PAST	Loss of balance?	YES	NEVER	PAST
Dizziness?	YES	NEVER	PAST	Lightheaded?	YES	NEVER	PAST
Trembling hands/feet?	YES	NEVER	PAST	Poor concentration?	YES	NEVER	PAST
Mood swings?	YES	NEVER	PAST	Slurred speech?	YES	NEVER	PAST

**Head**

Headaches?	YES	NEVER	PAST	Head injury?	YES	NEVER	PAST
Migraines?	YES	NEVER	PAST	Jaw/TMJ problems?	YES	NEVER	PAST
Lightheadedness?	YES	NEVER	PAST	Loss of balance?	YES	NEVER	PAST
Dizziness?	YES	NEVER	PAST				

**Skin**

Rashes?	YES	NEVER	PAST	Eczema?	YES	NEVER	PAST
Hives?	YES	NEVER	PAST	Dryness?	YES	NEVER	PAST
Acne, boils?	YES	NEVER	PAST	Itching?	YES	NEVER	PAST
Color changes?	YES	NEVER	PAST	Perpetual hair loss?	YES	NEVER	PAST
Lumps?	YES	NEVER	PAST	Night sweats?	YES	NEVER	PAST
Ulceration?	YES	NEVER	PAST	Sores?	YES	NEVER	PAST
Shingles?	YES	NEVER	PAST	Change in hair/nails?	YES	NEVER	PAST

**Eyes**

Spots in Eyes?	YES	NEVER	PAST	Cataracts?	YES	NEVER	PAST
Impaired vision?	YES	NEVER	PAST	Glasses/Contacts?	YES	NEVER	PAST
Blurriness?	YES	NEVER	PAST	Eyestrain?	YES	NEVER	PAST
Color blindness?	YES	NEVER	PAST	Tearing or dryness?	YES	NEVER	PAST
Double vision?	YES	NEVER	PAST	Glaucoma?	YES	NEVER	PAST
Eye pain?	YES	NEVER	PAST	Night blindness?	YES	NEVER	PAST
Swollen eyes?	YES	NEVER	PAST	Circles under Eyes?	YES	NEVER	PAST

**Ears**

Impaired hearing?	YES	NEVER	PAST	Ringing in ears?	YES	NEVER	PAST
Ear aches/Itch?	YES	NEVER	PAST	Excessive ear wax?	YES	NEVER	PAST

**Nose & Sinuses**

Frequent Colds?	YES	NEVER	PAST	Nose Bleeds?	YES	NEVER	PAST
Stuffiness?	YES	NEVER	PAST	Sinus Problems?	YES	NEVER	PAST
Post Nasal Drip?	YES	NEVER	PAST	Hayfever Allergies?	YES	NEVER	PAST
Loss of Smell?	YES	NEVER	PAST				

**Neck**

Pain or Stiffness?	YES	NEVER	PAST	Lumps?	YES	NEVER	PAST
Swollen glands?	YES	NEVER	PAST	Goiter?	YES	NEVER	PAST

**Mouth & Throat**

Frequent sore throat?	YES	NEVER	PAST	Sore Tongue?	YES	NEVER	PAST
Sores in mouth?	YES	NEVER	PAST	Gum problems?	YES	NEVER	PAST
Hoarseness?	YES	NEVER	PAST	Dental Problems?	YES	NEVER	PAST
Difficulty Swallowing?	YES	NEVER	PAST	Difficulty Speaking?	YES	NEVER	PAST
Loss of Taste?	YES	NEVER	PAST	Dental Cavities?	YES	NEVER	PAST
Teeth Grinding?	YES	NEVER	PAST	Jaw Clicks?	YES	NEVER	PAST
Sore Lips?	YES	NEVER	PAST	Copious saliva?	YES	NEVER	PAST

**Respiratory**

Cough?	YES	NEVER	PAST	Sputum?	YES	NEVER	PAST
Spitting up blood?	YES	NEVER	PAST	Bronchitis?	YES	NEVER	PAST
Wheezing?	YES	NEVER	PAST	Pleurisy?	YES	NEVER	PAST
Difficulty breathing?	YES	NEVER	PAST	Emphysema?	YES	NEVER	PAST
Pain with breathing?	YES	NEVER	PAST	Pneumonia?	YES	NEVER	PAST
Shortness of breath?	YES	NEVER	PAST	Asthma?	YES	NEVER	PAST
- While lying down?	YES	NEVER	PAST	Positive TB test?	YES	NEVER	PAST
- At night?	YES	NEVER	PAST				

**Cardiovascular**

Heart Disease?	YES	NEVER	PAST	Angina?	YES	NEVER	PAST
High/Low Blood Pressure?	YES	NEVER	PAST	Murmurs?	YES	NEVER	PAST
Blood Clots?	YES	NEVER	PAST	Fainting?	YES	NEVER	PAST
Phlebitis?	YES	NEVER	PAST	Palpitations/Fluttering?	YES	NEVER	PAST
Rheumatic Fever?	YES	NEVER	PAST	Chest Pain?	YES	NEVER	PAST
Swelling in ankles?	YES	NEVER	PAST	Stroke/Heart Attack?	YES	NEVER	PAST

**Urinary**

Pain on urination?	YES	NEVER	PAST	Increased frequency?	YES	NEVER	PAST
Frequency at night?	YES	NEVER	PAST	Unable to hold urine?	YES	NEVER	PAST
Bladder Infections?	YES	NEVER	PAST	Kidney stones?	YES	NEVER	PAST
Unable to urinate?	YES	NEVER	PAST				

**Gastrointestinal**

Trouble swallowing?	YES	NEVER	PAST	Black Stools?	YES	NEVER	PAST
Jaundice?	YES	NEVER	PAST	Diverticulitis/losis?	YES	NEVER	PAST
Nausea?	YES	NEVER	PAST	Liver disease?	YES	NEVER	PAST
Vomiting blood?	YES	NEVER	PAST	Heartburn?	YES	NEVER	PAST
Blood in stool?	YES	NEVER	PAST	Change in appetite?	YES	NEVER	PAST
Pain or cramps?	YES	NEVER	PAST	Vomiting?	YES	NEVER	PAST
Belching or passing gas?	YES	NEVER	PAST	Diarrhea?	YES	NEVER	PAST
Gallbladder disease?	YES	NEVER	PAST	Constipation?	YES	NEVER	PAST
Ulcers?	YES	NEVER	PAST	Hemorrhoids?	YES	NEVER	PAST
Stomach pain?	YES	NEVER	PAST	Change in thirst?	YES	NEVER	PAST
Bowel movement how often? _____				Colitis?	YES	NEVER	PAST
Is this a change? _____				Hiatal hernia?	YES	NEVER	PAST

**Circulation**

Cold hands/feet?	YES	NEVER	PAST	Varicose veins?	YES	NEVER	PAST
Deep leg pain?	YES	NEVER	PAST	Anemia?	YES	NEVER	PAST
Easy bleeding/bruising?	YES	NEVER	PAST	Thrombophlebitis?	YES	NEVER	PAST

**Musculoskeletal**

Joint pain or stiffness?	YES	NEVER	PAST	Broken bones?	YES	NEVER	PAST
Muscle spasms/cramps?	YES	NEVER	PAST	Back/Neck pain?	YES	NEVER	PAST
Weakness?	YES	NEVER	PAST	Arthritis?	YES	NEVER	PAST

**Emotional**

Depression?	YES	NEVER	PAST	Tension?	YES	NEVER	PAST
Mood Swings?	YES	NEVER	PAST	Suicidal thoughts?	YES	NEVER	PAST
Treated for emotions?	YES	NEVER	PAST	Anxiety/nervousness?	YES	NEVER	PAST

**Menstrual History**

Age at onset of menses? \_\_\_\_\_ Date of last PAP smear? \_\_\_\_\_ Was it normal? YES NO

Do you have any difficulty with gyn exam? YES NO

First day of last menstrual period: \_\_\_\_\_

Number of days between 1st day of one period and the 1st day of the next? \_\_\_\_\_

How many days does your period last? \_\_\_\_\_

Are your cycles regular? YES NO Do you bleed between cycles? YES NO

Any clotting? YES NO

Do you have any problems with:

Premenstrual tension?	YES NO	Pain?	YES NO
Heavy bleeding?	YES NO	Irregularity?	YES NO
Bleeding between periods?	YES NO	Breast pain/tenderness?	YES NO
Cramping?	YES NO	Abnormal PAPs?	YES NO

**Pregnancy History**

No. of pregnancies \_\_\_\_\_ No. of miscarriages? \_\_\_\_\_

No. of tubal/ectopic pregnancies? \_\_\_\_\_ Any difficulty conceiving? YES NO

No. of live births \_\_\_\_\_ No. of abortions? \_\_\_\_\_

Any complications of pregnancy? \_\_\_\_\_

**Birth Control History**

Are you sexually active? YES NO Sexual Orientation? \_\_\_\_\_

If yes, what birth control are you currently using? \_\_\_\_\_

What birth controls have you used in the past (please include dates)?

Birth control pills YES NO What kind? \_\_\_\_\_

IUD YES NO What kind? \_\_\_\_\_

Cervical Cap YES NO What kind? \_\_\_\_\_

Sponges YES NO Condoms YES NO Foam YES NO

Diaphragm YES NO Other: \_\_\_\_\_

Any problems encountered? \_\_\_\_\_

Any hormone medications used? \_\_\_\_\_

Pro vera YES NO DES YES NO Estrogen YES NO



Steroids    YES   NO      Morning After Pill    YES   NO      Thyroid meds    YES   NO  
 Cortisone    Yes or No      Other: \_\_\_\_\_

**Women's General History**

Do you do self-breast exams?    YES   NO      How Often? \_\_\_\_\_

Do you have any pain with intercourse?    YES   NO

Do you have any problems with:

Endometriosis?	YES   NO	Cancer?	YES   NO
Pelvic Inflamm. Disease?	YES   NO	Hot Flashes?	YES   NO
Difficulty Conceiving?	YES   NO	Cervical dysplasia?	YES   NO
Nipple discharge?	YES   NO	Bladder infections?	YES   NO
Breast lumps/tumors?	YES   NO	Hysterectomy?	YES   NO
Sexual difficulties?	YES   NO	Cervical abnormality?	YES   NO
Menopausal symptoms?	YES   NO	Uterine abnormality?	YES   NO
Bleeding/clotting problems?	YES   NO	Ovarian cysts?	YES   NO
Sexually Trans. Disease?	YES   NO	Vaginal discharge?	YES   NO

- If yes, circle which ones:

Herpes    Venereal Warts    Gonorrhea    Chlamydia  
 Syphilis    Trichomonas    Vaginal Infections

Is there anything else? \_\_\_\_\_

**Men's Health History**

Hernias?	YES   NEVER   PAST	Testicular Masses?	YES   NEVER   PAST
Penile pain?	YES   NEVER   PAST	Testicular pain?	YES   NEVER   PAST
Erectile difficulty?	YES   NEVER   PAST	Testicular swelling?	YES   NEVER   PAST
Penile discharge?	YES   NEVER   PAST	Prostate problems?	YES   NEVER   PAST
Sexually active?	YES   NEVER   PAST	Sexual Orientation?	YES   NEVER   PAST
Do you use protection?	YES   NEVER   PAST	Premature ejaculation?	YES   NEVER   PAST
- If yes, what type? _____		Monogamous relationship?	YES   NEVER   PAST
Impotence?	YES   NEVER   PAST	Any penile sores?	YES   NEVER   PAST
History of inguinal hernia?	YES   NEVER   PAST		

Sexually Transmitted disease? YES NO

- If yes, circle which ones:

Chlamydia    Gonorrhea    Condyloma    Herpes    Syphilis    Venereal warts

**Hobbies & Interests**

What are your main interests and hobbies? \_\_\_\_\_

What do you enjoy the most in life? \_\_\_\_\_

**Your Opinions About Your Health**

How does your condition affect you? \_\_\_\_\_

\_\_\_\_\_

What do you think is happening? \_\_\_\_\_

Why do you think this is happening to you? \_\_\_\_\_

What do you feel needs to happen for you to get better? \_\_\_\_\_

Is there any additional information about your health that you would like to add?

How much change are you willing to make at this time for improving your health?

circle one:    MINIMAL    SOME    COMPLETE

**Done.**

*Welcome to Namaste Health Center.*

*If you have any question, please ask us.*