Health Questionnaire

Name_____Date_____
Address _____
Telephone (circle preferred contact)_____Work_____Cell_____
Email:_____Referred By:_____
Height _____Weight_____Birthdate_____
Are you currently under a medical doctor's care? _____Explain_____
_____
_____
Doctor's name_____Telephone_____
Are you pregnant?_____ Childbirth history_____

List all known allergies_____
List all surgeries_____
List all medications (including over the counter):_____
List all supplements_____

Please put an "X" beside anything that is currently a health challenge. Put a "P" beside a past problem.

___constipation	___allergies	___swollen glands
___diarrhea	___parasites	___gall bladder
___hemorrhoids	___yeast infections	___impaired hearing
___indigestion	___insomnia	___cysts/tumors
___belching	___anemia	___infections
___flatulence/gas	___irritability	___antibiotic use
___ulcers	___hypoglycemia	___birth control pills
___colitis	___diabetes	___prostate problems
___arthritis	___sinus problems	___urination problem
___headaches	___hepatitis	___blood pressure
___fatigue	___herpes	___breast implants
___back aches	___asthma	___pregnancies
___vision problems	___Parkinson's	___psyche disorders
___dizziness	___cancer	___water retention
___acid reflux	___hiatal hernia	___difficult menstruation

Bowel Habits

How often do you have a bowel movement?_____At what time of day? _____
(Circle) Are they spontaneous? Only after eating? Requires straining? Effortless?
Do you have hemorrhoids or other rectal problems?_____
How often do you use a laxative? _____Herbal laxative?_____Stool softener?_____Suppositories?_____
Enemas? _____Have you ever had rectal bleeding?_____If yes, when?_____

Mark "Y" for yes and "N" for no. If yes, list amount and frequency.

___coffee_____diet programs_____
___tea_____ vegetarian/vegan_____
___carbonated drinks_____exercise (type and frequency)_____
___alcohol_____ hours sleeping_____
___tobacco_____ stress management (type)_____
___sugar/salt cravings_____ dairy products_____
___plain water intake per day_____Source of water _____

HOW MANY MERCURY FILLINGS DO YOU HAVE IN YOUR TEETH? _____
HOW MANY ROOT CANALS? _____WHEN? _____
ANY FAMILY HISTORY OF DIGESTIVE PROBLEMS, CANCER, HEART DISEASE?

What do you hope to achieve from this appointment?_____

Signature_____

Full Charge For Less Than 24 Hours Notice To Change Or Cancel Appointment