Londonderry Nurse Practitioners
Whole Health Consultants

HEALTH HISTORY QUESTIONNAIRE

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a major role in diagnosis and treatment. All information is strictly confidential.

I. GENERAL PATIENT INFORMATION

Date: ____/_____/____

Name: ____

Address: ____

City, State, Zip Code: ____

Home Phone: ________________________________Cell Phone: ____________________________

Email Address: ____

Age: ________ Date Of Birth: _____/_____/_____ Place Of Birth: _________________________

Gender: M / F   Height: __________ Weight: _________

How did you hear about our office: ____

Are you allergic to any medications?   Yes _______ No ________

If yes, please list: ____

Main Conditions you would like us to help you with and when they became a problem:

1.______________________________________ 4.____

2.______________________________________5.____

3.______________________________________6.____

To what extent do these problem(s) affect your daily activities, such as work, hobbies, or sleep?

What kind of treatment have you tried, and how have they worked?

What medications are you taking now?

Name	Date Started	Dosage

______________________________ ______________________ ___________________

List all Vitamins, Minerals and other Nutritional Supplements that you are taking now:

Name	Date Started	Dosage
______________________________	______________________	___________________
______________________________	______________________	___________________
______________________________	______________________	___________________
______________________________	______________________	___________________
______________________________	______________________	___________________
______________________________	______________________	___________________

II. PAST MEDICAL HISTORY

Indicate any you have had in the past, if so when:

□ Anemia	□ Diabetes	□ Hepatitis	□ Polio
□ Arthritis	□ Emphysema	□ High Cholesterol	□ Paralysis
□ Asthma	□ Epilepsy	□ Irritable Bowel	□ Rheumatic Fever
□ Bronchitis	□ Gall stones	□ Jaundice	□ Sinusitis
□ Bleeding Tendency	□ Glaucoma	□ Kidney Stones	□ Syphilis
□ Cancer	□ Gonorrhea	□ Mononucleosis	□ Sleep Apnea
□ CVA (Stroke)	□ Heart Attack	□ Meningitis	□ Tuberculosis
□ Chicken Pox	□ Heart Disease	□ Migraines	□ Thyroid Disease
□ Chronic fatigue syndrome	□ HIV/ AIDS	□ Measles	□Vein Condition
□ Crohn's Disease	□ High Blood Pressure	□ Pneumonia	

Other: ____

Immunizations:

□ Anthrax	□ Diphtheria	□ Hepatitis A	□ Hepatitis B	□ HIB	□ HPV
□ Influenza	□ Yellow fever	□ Lyme	□ Measles	□ Meningococcal	□ Mumps
□ Pertussis	□ Pneumococcal	□ Polio	□ Rabies	□ Rotavirus	□ Rubella
□ Shingles	□ Smallpox	□ Tetanus	□ Tuberculosis	□ Typhoid	□ Chickenpox

Other: ____

Indicate any injuries and when:

□ Back injury ________________________

□ Head Injury ________________________

□ Neck Injury ________________________

□ Other (describe) ____

Indicate any Diagnostic studies or Operations and when:

□ Colonoscopy	□ Gall Bladder
□ Mammography	□ Hysterectomy
□ Sigmoidoscopy	□ Tonsillectomy
□ Appendectomy	□ Other (describe)
□ Dental Surgery	□ Other (describe)

How often have you taken Antibiotics?

	1-3	4-6	7-9	10-12	13-15	16-18
Infancy/ Childhood	□	□	□	□	□	□
Teen	□	□	□	□	□	□
Adult	□	□	□	□	□	□

How often have you taken oral steroids (e.g. Cortisone, Prednisone, etc.):

	1-3	4-6	7-9	10-12	13-15	16-18
Infancy/ Childhood	□	□	□	□	□	□
Teen	□	□	□	□	□	□
Adult	□	□	□	□	□	□

III. PATIENT PROFILE

Using the table below please describe your physical activity:

Activity	Type/ Intensity	# Days per week	Duration (minutes)
Stretching/ Yoga			
Cardio/ Aerobics (Walking, Jogging, Biking, etc.)			
Strength Training (Weight lifting, Pilates, etc.)			
Sports or leisure			
Other (specify/describe)			

Do you follow a special diet/ nutritional program, check all that apply:

□ Low Fat □ Dairy Free □ No Wheat □ Vegan □ Low Sodium
□ Gluten Free □ Vegetarian □ High Protein □ Weight Loss □ Diabetic

Please indicate the beverages you drink, and how often you drink them:

Beverage Type	Daily Amount	Weekly Amount	Monthly Amount
Example: Coffee: ◙ reg □ decaf □ latte	2 – 8 oz cups	□	□
Water: □ tap □ filtered □ bottled			
Coffee: □ reg. □ decaf □ latte			
Tea: what type(s)? _______________			
Juice: □ natural □ fruit drinks			
Soda: □ regular □ diet			
Milk: □ whole □ 2% □ 1% □ skim			
Milk Alternative: type_____________			
Alcohol: □ wine □ beer □ liquor			
Other: ___________________________			

Please indicate the frequency that you eat the following:

How often do you eat:		2-3 times/mo	1 time/wk	2-3 time/wk	1 times/day	2-3 times/day
Fast food	□	□	□	□	□	□
Restaurant food	□	□	□	□	□	□
Vending machine food	□	□	□	□	□	□
Cafeteria or buffet food	□	□	□	□	□	□
Frozen meals	□	□	□	□	□	□
Home-cooked meals	□	□	□	□	□	□
Leftovers	□	□	□	□	□	□
Beef (hamburgers, steak, etc)	□	□	□	□	□	□
Pork (chop, loin, ham, bacon)	□	□	□	□	□	□
Liver	□	□	□	□	□	□
Lamb	□	□	□	□	□	□
Poultry (chicken, turkey, etc)	□	□	□	□	□	□
Deli meat, type:_________________	□	□	□	□	□	□
Fish type: ____________________	□	□	□	□	□	□
Soy foods, type:_________________	□	□	□	□	□	□
Beans, type:____________________	□	□	□	□	□	□
Crackers, type: _________________	□	□	□	□	□	□
Cookies, cake, muffins	□	□	□	□	□	□
Whole grains, type:______________	□	□	□	□	□	□
Fresh/raw vegetables	□	□	□	□	□	□
Cooked vegetables	□	□	□	□	□	□
Fruit, fresh or frozen	□	□	□	□	□	□
Canned vegetables or fruit	□	□	□	□	□	□
Margarine	□	□	□	□	□	□
Dairy (milk, yogurt, cheese, butter)	□	□	□	□	□	□
French fries	□	□	□	□	□	□
Fried meat (chicken, fish)	□	□	□	□	□	□
Foods w/added sweeteners/sugars Type: _________________________	□	□	□	□	□	□
Artificial sweeteners type:____________________________	□	□	□	□	□	□
Meal Replacements Type: _________________________	□	□	□	□	□	□

Do you have intestinal gas?

□ Daily
□ Excessive
□ Foul smelling
□Occasionally
□ Present with pain
□ Little odor

Weight History

Would you like to be weighed today? □ Yes □ No

Height _________ Weight __________ Desired Body Weight__________

Highest Adult Weight _________ When? __________ Weight 1 year ago ___________

Have you had any recent changes in your weight that you are concerned about? □ Yes □ No

If yes, please explain: ____

Digestive History:

Do you associate any digestive symptoms with certain foods □ Yes □ No

Please explain, ____

____

Please fill in the chart below with information about your bowel movements:

Frequency		**Consistency**		**Color**	
	□ More than 3x a day		□ Soft and well formed		□ Medium brown
	□ 1-3x a day		□ often float		□ Very dark or black
	□ 4-6x a week		□ Difficult to pass		□ Greenish color
	□ 2-3x a week		□ Diarrhea		□ Blood is visible
	□ 1 or fewer x a week		□ Thin, long or narrow		□ Varies a lot
			□ Small and hard		□ Dark brown
			□ Loose but not watery		□ Yellow, light care
			□ Alternating between loose/ watery		□ Greasy, shiny appearance

Do you take laxatives, what type/ brand and how often?

____

Please indicate how often you experience the following symptoms:

Heartburn	□ Often	□ Sometimes	□ Rarely
Gas	□ Often	□ Sometimes	□ Rarely
Bloating	□ Often	□ Sometimes	□ Rarely
Stomach pain	□ Often	□ Sometimes	□ Rarely
Nausea/ Vomiting	□ Often	□ Sometimes	□ Rarely
Diarrhea	□ Often	□ Sometimes	□ Rarely
Constipation	□ Often	□ Sometimes	□ Rarely

Diet History:

Do you have any diet restriction or limitations for any reason (health, cultural, religious, or other)?

□ Yes □ No please explain, ____

Please list any food allergies, sensitivities, or intolerances ______________________________________

____

Who prepares the majority of your meals? ___________________ Who shops for food? _________________

Where do you shop for food? ____

What percent of the foods you eat are… whole ________% organic_________% convenience _________%

If you do, how much time do you spend cooking/ preparing meal each day? ___________________________

Do you find cooking difficult □ Yes □ No please explain, ____

____

Do you smoke? □ Never □ In the past □ Currently □ How long _____________

Drug Use? □ Never □ In the past □ Currently □ Type/frequency _______ □ Prefer not to discuss

Women Only:

Do you practice birth control? □ Yes □ No   What type and for how long? ____________________________

Are you pregnant? □ Yes □ No   Is there a chance you could be pregnant? □ Yes □ No

Vaginal Discharge: Frequency____________________ Color______________________ Odor? □ Yes □ No

Regular menstrual cycle? □ Yes □ No Describe: ____

Number of children: _______ Number of pregnancies: _______ Age of first menstruation: ________

Average number of days of flow: _____ Average number of days of entire cycle: _____

Uterine bleeding/ spotting between periods □ Yes □ No How much and how often: ____________________

Age of Menopause (if applicable) _________

Do you experience any of the following pre-menstrual symptoms?

□ Nausea □ Depression □ Vomiting □ Irritability □ Water retention
□ Food cravings □ Dull pain, where? □ Headaches □ Sharp pain, where? □ Migraines
□ Breast tenderness □ Breast Swelling □ Anxiety □ Other: _________________________

Please complete the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color(normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)	□	□	□	□	□	□	□
Nausea (check if yes)	□	□	□	□	□	□	□
Other							

Men Only:

□ Swollen testes □ Testicular pain □ Impotence □ Premature Ejaculation
□ Feeling of coldness or numbness in external genitalia □ Other: ____________________________