EarthSong
Integrative Medicine & Midwifery

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ F ☐ M	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring Provider:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ TDaP	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other healthcare providers have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your herbs, supplements and prescribed medications		
Name	Strength of each dose	Frequency Taken
Allergies to medications, food, environment, animals, latex		
Name of the Allergen	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30+ minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Are you a vegetarian or Vegan?					
	Do you eat organic food, and if so how much/often?					
	How many different fruits and vegetables to you eat each day?					
	How much water or herbal tea do you drink each day?					
	Salt intake	☐ High	☐ Moderate	☐ Low		
	Fat intake	☐ High	☐ Moderate	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda/Carbonated Beverages		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No

Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying to become pregnant?			☐ Yes	☐ No
	If not trying to become pregnant, how are you preventing pregnancy?				
	Any discomfort with intercourse?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?			☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ F ☐ M	
Mother				☐ F ☐ M	
Sibling	☐ F ☐ M			☐ F ☐ M	
	☐ F ☐ M			☐ F ☐ M	
	☐ F ☐ M		**Grandmother** *Maternal*		
	☐ F ☐ M		**Grandfather** *Maternal*		
	☐ F ☐ M		**Grandmother** *Paternal*		
	☐ F ☐ M		**Grandfather** *Paternal*		

MENTAL-EMOTIONAL-SPIRITUAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you anxiety or panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Who is your support system?

Do you have spiritual/religious practices?

WOMEN'S HEALTH

How old were you when you first had a period?		
Date of first day of most recent period:		
Period every _____days		
Heavy periods, irregularity, spotting, pain, or abnormal discharge?	☐ Yes	☐ No
Number of pregnancies :_____ Number of live births : _____ Number of miscarriages/terminations: _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a uterine surgery (such as D&C, hysterectomy, or Cesarean)?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap test? _____ Have you had an abnormal pap in the last five years? _____		

Date and results of Last mammogram/breast ultrasound/thermogram?

Date of last bone density test?

Date of last colonoscopy?

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort
☐ Lungs	☐ Circulation	

Client's Signature: _____ Date: _____
Updated: _____ Date: _____
Updated: _____ Date: _____

Reviewed by Healthcare Provider: _____ Date: _____
Updated: _____ Date: _____
Updated: _____ Date: _____

REBECCA@EARTHSONGWELLBEING.COM • FAX: 833.689.9875
WWW.EARTHSONGWELLBEING.COM