Dr. Morrison's Medical Health History Questionnaire

Name: _____ Date: _____
Date of Birth _____ Age_____

Please list the most important reason(s) you came in today:
1. _____
2. _____
3. _____
4. _____

What other health concerns do you have at this time?
1. _____
2. _____
3. _____

Please list other doctors, chiropractors, acupuncturists and physical therapists you see and for what:
1. _____
2. _____
3. _____

List prescription medicine you now take (include dosage, reason you take it):

Medication	Dose per Day	How long?	Reason for medication

List over-the-counter medicines, vitamins, and food supplements you take and why?:

Supplement	Dose per Day	How long?	Reason for medication

Are there any adverse effects from any of the above? If so what is it and is it a concern?
_____
_____
_____

Medical History (Please include dates):

Any Major illnesses that have been diagnosed or suspected:

Illness	When?	How diagnosed? (lab, imaging, symptoms)

Injury/Trauma/Accidents
What? What was injured? When?

_____
_____
_____

Surgeries/Hospitalizations:
Surgery/Hospitalization When?

_____
_____
_____

Anaphylactic Reactions or severe reactions (medications, food, stings) to:

_____
_____
_____

Sensitivities (medication, supplements, foods, etc.)

_____
_____

What is your blood Type? A+ B+ AB+ O+ A- B- AB- O-

Recent Medical Care: Where did you last receive medical care? _____
For what reason(s)? _____

Date of last physical exam: _____ Date of last TB test: _____
Date of last lab work: _____ Date of last tetanus shot: _____

Do you visit the dentist annually or more frequently? Y N
Characterize your dental health
Poor __ (more than 5 fillings) ___ more than one root canal
Good __ (3-4 fillings) ___ 1 root canal
Great __ (0-2 fillings) ___ no root canals
Gum-periodontal health ____ Mild bleeding occasionally ___ Bleeding regularly
____ more extensive swelling/gum inflammation
Height_____ Weight_____ Max weight _____when? _____ Desired weight ____

Circle if the symptom has occurred in the **last year**. Please **check mark** if the symptom occurred in **the past**, **1** for not often, **2** for occasional, **3** for often.

General	Weight gain Weight loss Weight gain (20lbs) Weight loss (20 lbs) History of dieting	Chronic fatigue Afternoon fatigue Weakness Excessive thirst Anemia	Spontaneous sweating Night sweats Fever/chills	Heat intolerance Cold intolerance Cold hands/feet Other:
Skin	Dry skin Itchy skin Rashes Hives Bruise easily	Acne Eczema Psoriasis Shingles Fungal Rash/ringworm	Athlete's foot Nail fungus Moles Varicose veins Bumpy skin back of arms	Any change to nails Any change to skin color Any change to moles Other:

Head	Headaches Migraines	Dizziness Vertigo	Trauma Hair Loss	Seizures Other:
Eyes **Last exam___**	Dry eyes Watery eyes Itchy eyes Eye pain Red eyes Eye discharge	Blurred vision Double vision Sensitive to light Poor night vision	Styes Cataracts Vision loss Other:	Vision correction: Nearsighted Farsighted Contacts Glasses Laser
Ears	Ear pain Itchy ears Waxy ears	Discharge from ears Ringing in ears Hearing loss	Ear infections Ear infections as child	Hearing Aids Other
Nose & Sinuses	Itchy nose Discharge from nose Phlegm	Hay-fever/Allergies Post nasal drip Nosebleeds Loss of smell	Breathes thru mouth Snores	CPAP use Other:
Mouth & Throat Last dental exam _____	Dry mouth Itchy mouth/lips Sores on mouth/lips Bad breath	Sore throat Difficulty swallowing Loss of taste Hoarseness	Dentures Inflamed/bleeding gums Teeth sensitivity Braces	Jaw clicking TMJ
Neck	Neck pain	Swollen glands	Trauma	Other:
Respiratory	Shortness of breath Wheezing Pain with breath Coughing up blood	Asthma Bronchitis/Pneumonia Persistent cough	Exposure to: Chemicals Solvents Particulates	Tuberculosis Other:
Cardiovascular Last EKG ___	High blood pressure Low blood Pressure High Cholesterol Chest pain Heaviness in legs Bleeding issues	Heart races Palpitations Chest tightness Difficulty breathing at night Swelling in ankles Stroke	Cold hands/feet Purple fingers/lips Heart murmur Dizzy on standing Exhaustion with mild exertion	Clots Varicose veins Spider veins Calf pain-night Calf pain-walking Other:
Gastrointestinal (upper) Last endoscopy ------	Poor appetite Excessive appetite/thirst Changes in appetite Trouble swallowing Stomach pain	Nausea Vomiting Burping Belching Heartburn H. pylori Ulcers	Intolerance to foods: (list food &rxn))	Fatigue after eating Anal itching Liver disease Gall bladder disease Treated for parasites
Gastrointestinal (lower) Last colonoscopy ___ Last rectal exam ____	Abdominal pain Abdominal bloating Gas/flatulence History of abdominal/pelvic surgery	Constipation <1 stool a day Painful Stool Hemorrhoids Blood in stools Blood on stools	Stool hard to pass Foul smelling stool Loose stools Frequent stools >3 day Undigested food in stools	Stool shape: -one piece -little pellets -breaks up -other: Color: -yellow -green -brown -black

Kidney/Urinary	Frequent urination Urinate <3x day Can't hold urine Urination with cough or sneeze	Kidney infections Bladder infections Urination at night Pain/burning with urination	Dripping after urination Bed-Wetting Other:	Color: Light yellow Dark yellow Red urine Cloudy Strong smelling
Musculoskeletal	Pain in- Arms Shoulders Neck Hands Upper back Lower back Hips Legs Knees Feet	Painful bones Tight Shoulders Pain Muscles Swollen knees/elbows Burning Spasms/cramps Morning stiffness	Chronic pain Loss of height Osteoporosis Unable to sit straight Activities Limited due to pain	Herniated/bulging disc Arthritis Rheumatoid arthritis Tendonitis # Broken bones ___ DEXA Y N When ____ Normal?
Neurological	Fainting Dizziness/vertigo Numbness/tingling Where?_____ Trembling hands	Poor Concentration Memory loss -long-term -short term Lack of alertness	Loss of grip Loss of muscle tone Muscle weakness Head heavy Heavy extremities	Head trauma Other:
Endocrine	Hypothyroid -surgical -Hashimoto's -unknown cause Hyperthyroid Cold hands/feet Cold intolerance	Hypoglycemia Hyperglycemia -DM1 -DM2 -Medications Y N Excessive thirst	Fatigue Poor appetite Excessive Hunger	Unexplained weight gain / loss Other:
Immune	Slow wound healing Reactions to Vaccines Cancer Mononucleosis	Chronic fatigue syndrome Auto immune disorder _____	Chronically swollen glands Chronic Infections Chicken pox Shingles	Frequent colds/flus Herpes Warts Other:
Women only	Menses: Age of first: _____ Days bleed:_____ Length of cycle:_____ Date of last menses:__ Heaviest flow day:___ Heavy days #pads/tampons:_____ Clots? Cramps 1 2 3 4 5 Medication Y N Occ Hysterectomy _____ Fibroids Cystic Pain	Sexually active Y N # Pregnancies ____ # Live births ____ Gender you are sexually active with? Men Women Both Type of birth control? -Birth control pills -IUD Cu+ / Hormone -Condoms -Implant -Depo shot - Vasectomy -Other	Spotting between menses PMS -irritability -moodiness -crave sweet -crave salt -bloating -breast tenderness -crave salt Fatigue with menses Miss menses Irregular menses	Vaginal -itching -discharge -odor -dryness Infections -yeast -bacterial -viral History of STI Y N _____ Difficulty conceiving Libido 1-5 _____
Women only	Breast Monthly self exam Y N Fibrous breast Breast fed a child Implants Reduction Nipple discharge	History of mammogram Abnormal mammogram + PAP history -Cryo -LEEP	Menopause Age __Yrs ago___ Hot flashes Night sweats Moodiness Brain fog Vaginal dryness	Hormone replacement -standard -natural -herbal Other:

Men only PSA test ____ Prostate exam _____	Sense of full bladder Difficulty urinating Pain with urination Wake >1x to urinate Dripping after urination Strain with urination Discharge from penis Sore on penis	Discharge from penis Sore on penis History of STI Y N Premature ejaculation Erectile dysfunction Sexual difficulties Libido 1-5 ___	Testicular pain Testicular lump Testicular monthly exam Y N History of prostatitis Pain in genitals Hernia	Sexually active Y N Gender you are sexually active with? Men Women Both Type of birth / STI control? Vasectomy_____ Condoms _____
Emotional & Mental	Unexplained crying Loss of interest Boredom Restless Panic attacks Aggression	Self-blame Excessive guilt Socially withdrawn Irritability Worry Loss of confidence / self-esteem	Indecisiveness Inability to concentrate Anxiety Overly concerned with social encounters Thought of suicide	Memory impaired -recall words -learn new tasks Unable to recognize or identify objects Disturbance in planning or execution of plan
Sleep	Difficulty falling Difficulty staying Wake refreshed	Wake catching breath Snore Wake tired	Hours sleep ____ Hours Sleep needed ____	Apnea Treatment Y N
Exercise	Never 0-2 x week 2-5 x week 5 + x week	Intense Moderate Easy going	Bike Swim Hike Weights Run Gym	Other:
Lifestyle	Spiritual participation Yoga Tai chi Chi kung Meditation Other:	Art Knitting Quilting Drawing Photography Other _____	Married ____ # Children # Children living with you ____	Use of Daily/Weekly/Monthly Alcohol ____ Marijuana ____ Tobacco ____ Other ____
Average Diet (what you eat) **Quantity ?** **Water** **Coffee** **Tea** **Wine** **Beer** **Cocktail** **Other:**	Breakfast When What: Beverages	Lunch When What: Beverages	Dinner When What: Beverages	Snacks When What: Other Beverages

Has anyone in your family had and who?

Alcoholism	Arthritis	Asthma	Cancer: type _____
_____	_____	_____	_____
_____	_____	_____	_____

Glaucoma	Diabetes	Heart disease	Genetic disorder
_____	_____	_____	_____
_____	_____	_____	_____

Mental illness	Gastrointestinal	Thyroid disease	Auto-immune
_____	_____	_____	_____
_____	_____	_____	_____

Other_____

Rate your stress level (1=low 10=very high) 1 2 3 4 5 6 7 8 9 10
Circle and rate the contributors
Health ___ Work ___ Money ___ Kids ____ Marriage ____ Parents ___ Home ___
Other _____
In your everyday life , your present faith/spiritual practices are (1= Important, 10= very important)
1 2 3 4 5 6 7 8 9 10
Please rate your motivation to affect change in your health (1= unmotivated, 10= highly motivated)
1 2 3 4 5 6 7 8 9 10

Hobbies:
_____
What do you do that brings you joy? _____
_____

Anything Else? _____
_____

Patient signature _____Date _____

Thank you for taking the time to provide this information so that we may provide you with more effective care.