ProHealth Center
New Patient Health History Questionnaire

GENERAL INFORMATION

Name _____ Today's Date_____

Occupation _____ Date of Birth _____

If you are currently under the care of a physician or other health care professional, please provide name & primary condition treated: _____

_____

List any major illnesses with approximate dates: _____

_____

List any surgeries or surgical procedures with approximate dates: _____

_____

List any past serious injuries or accidents: _____

_____

Any household pets or other animals with whom you or your family are in close contact?

_____

COMPLAINTS/CONCERNS

Please your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			
8.			

ALLERGIES

Medication/Supplement/Food	Reaction

IMMUNIZATION HISTORY

Have you received any vaccinations in the last 5 years? YES _____ NO _____ If yes, please list below:

_____

DENTAL HISTORY

Do you currently have any amalgam, silver, metal, and/or gold fillings? YES _____ NO _____

If yes, please list how many and which type: _____

How long have you had these fillings? _____

Have you had any fillings removed in the last 12 months? YES _____ NO _____

Have ever had a root canal? YES _____ NO _____ If yes, please list the approximate date/year: _____

MEDICATIONS & SUPPLEMENTS

Please list all medications (including prescription, nonprescription, antibiotics) and supplements (including vitamins, minerals, herbal supplements) that you are currently taking and/or have taken in the last 6 months.

Medication Name AND/OR Supplement Name/Brand	Dosage	Last Taken

Have your medications or supplements ever caused you unusual side effects or problems? YES ____ NO ____

If yes, please describe: _____

SLEEP / REST

Average number of hours you sleep? >10 8-10 6-8 <6

Do you have trouble falling asleep? YES _____ NO _____

Do you feel rested upon awakening? YES _____ NO _____

Do you have problems with insomnia? YES _____ NO _____

Do you snore? YES _____ NO _____

Do you use sleeping aids? YES _____ NO _____ Explain if yes: _____

LIFESTYLE INDICATORS

TOBACCO HISTORY

Currently using tobacco? YES _____ NO _____ How many years & amount? _____

If yes, what type? Cigarette ____ Vape/Juul ____ Cigar ____ Pipe ____ Patch/Gum ____ Chew/Dip ____

Previous smoking: How many years? _____ Packs/Amount per day: _____ Date you quit: _____

Are you exposed to 2nd hand smoke? YES _____ NO____ If yes, explain _____

ALCOHOL HISTORY

How many drinks currently per month? *1 drink = 5 ounces wine, 12 ounce beer, 1.5 ounces spirits*

None _____ 1-3 _____ 4-6 _____ 7-9 _____ 10-12 _____ >12 _____

Previous alcohol intake? YES _____ NO_____ If yes, Mild _____ Moderate _____ Heavy _____

CAFFEINE INTAKE

How many cups of coffee per day? *1 drink = 8 oz* None ____ 1-3 ____ 4-6 ____ 7-9 ____ >10 ____

How many cups/cans of soda per day? *1 drink = 8 oz* None ____ 1-3 ____ 4-6 ____ 7-9 ____ >10 ____

Is the soda you drink diet soda? YES _____ NO_____

WATER INTAKE

How many oz of water do you drink per day? _____ Type: Bottled ___ Tap ___ Well ___ Filtered ___

FAMILY HISTORY

Family Member	Living (Y or N)	Age or Age at Death	Health Conditions, Diseases, Illnesses
Mother			
Father			
Siblings			
Children			
Grandparents			

MALE HISTORY

Have you had a vasectomy? YES _____ NO ____ If yes, date of procedure: _____

Have you had a reverse vasectomy? YES _____ NO ____ If yes, date of procedure: _____

Have you experienced symptoms related to the vasectomy? YES _____ NO ____ Explain: _____

_____

Do you have a history of prostate problems? YES _____ NO ____ Explain: _____

_____

Date of last prostate exam: _____

Most recent PSA results: _____ Date Drawn: _____

How often do you exercise? Never ____ Rarely ____ Occasionally ____ Regularly ____ Every Day ____

What type of exercise? _____

Other information for us to know: _____

_____

FEMALE HISTORY

FOR CYCLIC-AGE WOMEN

Age at first period? _____ Date of last menstrual period: _____ Length of current cycle: _____

Cycle Frequency _____ Average length of period: _____ Painful periods? YES _____ NO _____

Clotting? YES _____ NO____ Have you ever skipped a period? YES ____ NO____ For how long? _____

Do you use contraception? YES _____ NO____ If yes, what type? _____

Are you currently on the pill? YES _____ NO____ Does it agree with you? _____

In the second half of your cycle, do you have symptoms of breast tenderness, water retention, irritability, and/or PMS? YES _____ NO____ If yes, explain? _____

Date of last mammogram _____ Breast biopsy with date _____

Last PAP test date _____ Normal _____ Abnormal _____

Other information for us to know: _____

_____

PREGNANCY HISTORY

	YES or NO	How Many?
Pregnancies		
Miscarriages		
Caesareans		
Abortions		
Vaginal Deliveries		
Living Children		

Have you ever had any of the following?

Baby over 8 lbs: YES ____ NO ____ Toxemia: YES ____ NO ____ Preeclampsia: YES ____ NO ____

Post partum Depression: YES ____ NO ____ Gestational Diabetes: YES ____ NO ____

Did you breast feed your child(ren)? YES _____ NO _____ Length of time? _____

FOR MENOPAUSAL WOMEN

Age at onset of menopause? _____ Year of onset: _____

When you were cycling, would you consider your cycle regular? YES ____ NO ____ If no, explain: _____

_____

What was your typical menstrual flow? Light _____ Moderate _____ Heavy _____

Have you had a hysterectomy? Complete (ovaries and uterus) _____ Partial (uterus only) _____

Date of hysterectomy _____ Reason: _____

Date of last mammogram _____ Breast biopsy with date _____

Last PAP test date _____ Normal _____ Abnormal _____

Date of last bone density test _____ Results: High _____ Low _____ Normal _____

Do you take: Estrogen ____ Ogen ____ Estrace ____ Premarin ____ Progesterone ____ Provera ____

Other _____

How long have you been on hormone replacement? _____

Other information for us to know: _____

_____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due at time of service rendered.

Patient/Guardian's signature: _____ Date: _____