

**INITIAL HISTORY QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any of the conditions/symptoms listed below? Yes No

1. Cardiovascular \_\_\_\_\_ \_\_\_\_\_
	1. Heart attack \_\_\_\_\_ \_\_\_\_\_
	2. Stroke \_\_\_\_\_ \_\_\_\_\_
	3. High blood pressure \_\_\_\_\_ \_\_\_\_\_
	4. Heart murmur \_\_\_\_\_ \_\_\_\_\_
	5. Shortness of breath with exertion \_\_\_\_\_ \_\_\_\_\_
	6. Valvular problems \_\_\_\_\_ \_\_\_\_\_
	7. Chest pain \_\_\_\_\_ \_\_\_\_\_
	8. Varicose veins/venous stasis \_\_\_\_\_ \_\_\_\_\_
	9. Phlebitis \_\_\_\_\_ \_\_\_\_\_
	10. Pulmonary embolus \_\_\_\_\_ \_\_\_\_\_
2. Respiratory:
	1. Chronic cough \_\_\_\_\_ \_\_\_\_\_
	2. Emphysema \_\_\_\_\_ \_\_\_\_\_
	3. Asthma \_\_\_\_\_ \_\_\_\_\_
	4. Sleep apnea \_\_\_\_\_ \_\_\_\_\_
	5. Wheezing \_\_\_\_\_ \_\_\_\_\_
	6. TB \_\_\_\_\_ \_\_\_\_\_
3. Gastrointestinal
	1. Hiatal hernia \_\_\_\_\_ \_\_\_\_\_
	2. Heart burn/reflux \_\_\_\_\_ \_\_\_\_\_
	3. Stomach ulcers \_\_\_\_\_ \_\_\_\_\_
	4. Gallbladder disease/gallstones \_\_\_\_\_ \_\_\_\_\_
	5. Chronic constipation \_\_\_\_\_ \_\_\_\_\_
	6. Chronic diarrhea \_\_\_\_\_ \_\_\_\_\_
	7. Blood with bowel movement \_\_\_\_\_ \_\_\_\_\_
	8. Previous abdominal surgery \_\_\_\_\_ \_\_\_\_\_
	9. Difficulty swallowing \_\_\_\_\_ \_\_\_\_\_
	10. Hernias \_\_\_\_\_ \_\_\_\_\_

Yes No

* 1. Jaundice \_\_\_\_\_ \_\_\_\_\_
	2. Liver disease/hepatitis \_\_\_\_\_ \_\_\_\_\_
1. Gynecological:
	1. Pregnancies \_\_\_\_\_ \_\_\_\_\_
	2. Irregular menstrual cycle \_\_\_\_\_ \_\_\_\_\_
	3. Premenstrual bloating/cramping \_\_\_\_\_ \_\_\_\_\_
	4. Infertility \_\_\_\_\_ \_\_\_\_\_
	5. Abnormal pap smear \_\_\_\_\_ \_\_\_\_\_
2. Endocrine:
	1. Diabetes \_\_\_\_\_ \_\_\_\_\_
	2. Diabetes treatment (diet/pills/insulin) \_\_\_\_\_ \_\_\_\_\_
	3. High cholesterol/triglycerides \_\_\_\_\_ \_\_\_\_\_
	4. Thyroid problems \_\_\_\_\_ \_\_\_\_\_
3. Musculo-skeletal:
	1. Arthritis \_\_\_\_\_ \_\_\_\_\_
	2. Joint pain/joint stiffness \_\_\_\_\_ \_\_\_\_\_
	3. Gout \_\_\_\_\_ \_\_\_\_\_
	4. Difficulty walking \_\_\_\_\_ \_\_\_\_\_
	5. Back problems \_\_\_\_\_ \_\_\_\_\_
	6. Limitation of movement \_\_\_\_\_ \_\_\_\_\_
	7. Weakness \_\_\_\_\_ \_\_\_\_\_
4. Psychosocial:
	1. Psychiatric problems \_\_\_\_\_ \_\_\_\_\_
	2. Depression \_\_\_\_\_ \_\_\_\_\_
	3. Mood changes \_\_\_\_\_ \_\_\_\_\_
	4. Hallucinations \_\_\_\_\_ \_\_\_\_\_
	5. Disorientation \_\_\_\_\_ \_\_\_\_\_
	6. Seizures \_\_\_\_\_ \_\_\_\_\_
	7. Eating disorders \_\_\_\_\_ \_\_\_\_\_
	8. Disabled \_\_\_\_\_ \_\_\_\_\_
5. Neurologic:
	1. Numbness/tingling \_\_\_\_\_ \_\_\_\_\_
	2. Fainting/blackouts \_\_\_\_\_ \_\_\_\_\_
	3. Dizziness \_\_\_\_\_ \_\_\_\_\_
	4. Tremors \_\_\_\_\_ \_\_\_\_\_
	5. Headaches \_\_\_\_\_ \_\_\_\_\_
6. Urologic:
	1. Prostate problems \_\_\_\_\_ \_\_\_\_\_

**Please answer the following:** Yes No

1. Do you smoke (if yes, how much?) \_\_\_\_\_ \_\_\_\_\_
2. Do you drink regular coffee (if yes, how much?) \_\_\_\_\_ \_\_\_\_\_
3. Do you drink regular soda (if yes, how much?) \_\_\_\_\_ \_\_\_\_\_
4. Do you eat candy/other sweets on a regular basis? \_\_\_\_\_ \_\_\_\_\_
5. Do you drink alcohol daily? \_\_\_\_\_ \_\_\_\_\_
6. Do you eat or snack after 8pm? \_\_\_\_\_ \_\_\_\_\_
7. Do you eat when you are not hungry or when stressed? \_\_\_\_\_ \_\_\_\_\_
8. Are you able to exercise? Is so, how often? \_\_\_\_\_ \_\_\_\_\_
9. Do you need to sleep on more than one pillow to breathe? \_\_\_\_\_ \_\_\_\_\_
10. Do you suffer with intestinal cramps, gas pains, fatty food

Intolerance, indigestion, heartburn? \_\_\_\_\_ \_\_\_\_\_

1. Do you have hemorrhoids or other rectal problems? \_\_\_\_\_ \_\_\_\_\_
2. Do you have a history of heart disease or high blood pressure? \_\_\_\_\_ \_\_\_\_\_
3. Do you have breathing problems with exertion? \_\_\_\_\_ \_\_\_\_\_
4. Do you have any circulation problems in your legs? \_\_\_\_\_ \_\_\_\_\_
5. Do you have large varicose veins? \_\_\_\_\_ \_\_\_\_\_
6. Do your feet, ankles, knees, hips ache and/or swell? \_\_\_\_\_ \_\_\_\_\_
7. Do you have significant back pain? \_\_\_\_\_ \_\_\_\_\_
8. Do you get up at night to urinate? \_\_\_\_\_ \_\_\_\_\_
9. Do you leak urine when you strain, cough, sneeze or lift? \_\_\_\_\_ \_\_\_\_\_
10. If you still have periods, are they regular? \_\_\_\_\_ \_\_\_\_\_
11. Do you use birth control? What kind? \_\_\_\_\_ \_\_\_\_\_
12. Do you use hormones? What kind? \_\_\_\_\_ \_\_\_\_\_
13. Do you have any sleep problems? What kind? \_\_\_\_\_ \_\_\_\_\_
14. Do you have any respiratory problems? What kind? \_\_\_\_\_ \_\_\_\_\_
15. When was your last chest x-ray? \_\_\_\_\_\_\_\_\_\_\_\_ year
16. When was your last rectal exam? \_\_\_\_\_\_\_\_\_\_\_\_ year
17. When was your last EKG? \_\_\_\_\_\_\_\_\_\_\_\_ year

Yes No

1. Have you ever tried Weight Watchers, OA, Optifast, Slimfast,

Atkins, fasting, Phen-fen physician supervised diet, other?

(please circle) \_\_\_\_\_ \_\_\_\_\_

1. What is the most weight you ever lost at one time? \_\_\_\_\_\_\_\_\_\_\_\_ lbs.
2. How long did you keep off that weight before regaining? \_\_\_\_\_\_\_\_\_\_\_\_ mos.
3. How old were you when you first became seriously overweight? \_\_\_\_\_\_\_\_\_\_\_\_ age
4. Do you have a history of an eating disorder? \_\_\_\_\_ \_\_\_\_\_

 Past, Present, No history (please circle)

1. Do you make yourself vomit, abuse laxatives or water pills \_\_\_\_\_ \_\_\_\_\_
2. Have you ever been abused? \_\_\_\_\_ \_\_\_\_\_

 sexually, verbally, emotionally, physically (please circle) \_\_\_\_\_ \_\_\_\_\_

1. Do you have a family history of heart disease? \_\_\_\_\_ \_\_\_\_\_
2. Do you have a family history of diabetes \_\_\_\_\_ \_\_\_\_\_
3. Do you have a family history of cancer? \_\_\_\_\_ \_\_\_\_\_
4. Have you seen any physicians in the last 5 years? \_\_\_\_\_ \_\_\_\_\_

 When?

 What for?

THANK YOU FOR ANSWERING THIS LENGHTY QUESTIONNAIRE!!!

ANWERING THESE QUESTIONS HELPS US TO HELP YOU BETTER.

*3/09 bmb*