Patient Name: _____ Date of Birth: _____

Integrative Medical Center of Arkansas

Confidential
Health History
Questionnaire

Today's Date _____

Name (Last, First, Mi)			Social Security #
Birthdate	Gender	Marital Status M S D	Home Phone
Address			Cell Phone
			Work Phone
Email Address			o Do not use my email to contact me
Employer and Job Title			
Emergency Contact Name	Contact Phone		Referred by
Personal Physician's Name			Physician's Phone
Preferred Pharmacy Name			Pharmacy Phone

HISTORY

Reason for Consultation / Evaluation: _____

Health Concerns/Symptoms (Please describe in detail): _____

_____

_____

_____

_____

Are you currently under the care of a healthcare professional for a medical/health condition: o No o Yes

If yes, please describe condition(s): _____

_____

Please bring a copy of any Lab results that have been performed within the last year. This can save you money so labs won't have to be repeated.

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PAST MEDICAL HISTORY

Please check any medical conditions or health problems that you currently have or have had in the past:

Condition	Yes	No	Condition	Yes	No
Headaches (Migraines)			Heart Disease		
Seizure Disorder			Chest Pain		
Recurrent sinus infections			Irregular Heartbeat		
Seasonal Allergies			High Blood Pressure		
Emotional/Psychiatric Illness			Blood Clotting Problems		
Depression			Bleeding Disorder		
Anxiety/Excessive Stress			Stroke/vascular Disease		
Asthma			Constipation/diarrhea		
Chronic Bronchitis			Hepatitis/Liver Disease		
Lung/breathing problems			Kidney Disease		
Chronic Indigestion			Menstrual Disorders		
Stomach Ulcers			Reproduction Problems		
Intestinal Disease			Prostate Problems		
Skin Problems			Sexual/Libido Problems		
Back Pain/Sciatica			Tendonitis		
Herniated Disc			Chronic Pain		
Neck Pain			Shoulder Problems		
Chronic Muscle/Joint Pain			Osteoarthritis		
Carpal Tunnel Syndrome			Rheumatoid Arthritis		
Fibromyalgia			Artificial Joint(s)		
Diabetes			Cancer		
Thyroid Disease			Psoriasis or Eczema		

List any additional health problems not listed above: _____

_____

_____

Preventive Tests	**Month/Year of Last Test**	**Test Results**
Cholesterol		
Bone Density		
Colonoscopy		
Exercise Stress Test		

List any additional surgeries/operations you have had and when: _____

_____

_____

_____

_____

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MEDICATION/SUPPLEMENTATION

List current medications (or those you have taken within the last year). Attach a separate page if more room is needed.

Medication Name	Date Started	Date Stopped	Dosage (amt/#daily)

Nutritional supplements, vitamins, herbs, and homeopathic remedies taken: _____

_____

_____

_____

_____

Medication Allergies: _____

_____

_____

_____

Environmental/Food Allergies: _____

_____

_____

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FAMILY HISTORY

For the conditions listed, check Yes or No if anyone in your family has been affected, then write the relationship of the relative with the condition/disease on the adjacent line.

Condition	No	Yes	Relationship
Heart Disease			
High Blood Pressure			
Diabetes			
Arthritis			
Skin Disorders			
Breast Cancer			
Uterine/Ovarian Cancer			
Prostate Cancer			
Colon Cancer			
Other Cancer			

List any other disease/condition in your family and the relationship: _____

_____

_____

MEN

Date of last prostrate exam: _____

Are you concerned with loss of muscle mass, tone, or strength? O No O Yes

Have you had problems with urination {decreased stream/frequent night urination)? O No O Yes

Do you perform periodic testicular self-examinations? O No O Yes

Has your abdominal girth and weight been increasing? O No O Yes

WOMEN

Are you pregnant? O No O Yes Last menstrual cycle: _____

Date of last pap/pelvic/breast exam: _____ O Normal O Abnormal: _____

Last mammogram: _____ O Normal O Abnormal: _____

Do you perform monthly breast self-exams? O No O Yes How many pregnancies? _____ # of children _____

Taking/have taken hormones/oral contraceptives: O No O Yes If yes, list any you have taken and when: _____

_____

List problems or concerns about taking hormone replacement therapy: _____

_____

Have you had a hysterectomy? O No O Yes When? _____ Were your ovaries removed? O No O Yes

Describe menstrual irregularities: _____

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SOCIAL HISTORY / PERSONAL HEALTH HABITS

Check all that apply:

My health is:	O excellent	O good	O fair	O poor
My nutrition intake is:	O excellent	O good	O fair	O poor
My physical fitness is:	O excellent	O good	O fair	O poor
My stress level is:	O a lot of stress	O often fatigued	O sad/blue	O trouble dealing with stress

What are your major stresses: _____
_____
_____

Do you practice meditation/stress reducing techniques? O No O Yes

Dietary Habits:

O No special diet habits O Avoid red meats O Minimize fat O Minimize Carbs
O Vegetarian O Emphasize fruit/veggies O Try to eat healthy O Avoid dairy/cheese
O I commonly eat at fast food restaurants O I commonly eat pre-packaged foods
I commonly consume: O Coffee O Soft Drinks O Diet Drinks O Candy/chocolate O Chips/crackers

I experience: O Nausea O Vomiting O Gas O Bloating O Constipation O Diarrhea O Cramping

How often do you have a bowel movement? _____

Exercise Habits:

O No special exercise habits O I routinely exercise _____hour(s) _____times per week.
O Aerobic exercise O Strength exercise/weights O Swim/dance O Flexibility (yoga/tai chi)
Other: _____

Tobacco History:

O I have never smoked cigarettes or chewed tobacco.
O I now smoke_____packs of cigarettes per day. I have smoked for_____years.
O I quit smoking in_____ (mo/yr). I smoked_____packs/day for_____years.
O I smoke cigars/pipe.

Alcohol History:

O I never drink alcohol.
O I drink occasionally or socially.
O I regularly drink _____ alcoholic drinks/day.
O I have a family history of alcoholism.

List routine hobbies/sports/recreational activities: _____
_____

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Vitals

Height: _____ Weight: _____ B/P: _____ Pulse: _____

Clinician's Notes/Impressions:

Exam:_____

_____

_____

_____

Impression:_____

_____

_____

_____

_____

_____

_____

Diagnosis:

1._____

2._____

3._____

_____

_____

Strengths_____

Weaknesses_____

Treatment Plan / Recommendations

1._____

_____

2._____

_____

3._____

_____

4._____

_____

Medications/Supplements

1._____

_____

2._____

_____

3._____

_____

4._____

_____

Healthcare Provider Signature: _____ Date:_____