SASTUN CENTER

Name: ____

Health History Questionnaire

Date of Birth: _________________ Today's Date: _________

Address: ______________________________________ City, ST: ___________________________ Zip: _________

Phone Number: ___________________ (Home) ____________________ (Work) ____________________ (Mobile)

Email Address: ____

Emergency Contact: ______________________ Phone: _______________ Referred by: ________________________

Reason for visit: _______________________________________ Date condition began (be specific): _____________

What are your expectations and goals for the visit? ____

____

What prior experiences have you had with complementary and alternative medicine? ________________________

____

Health Concerns (Please rank by priority) Example: Headache – August 2000 – 3x/week – mild/mod/severe

Concern	Onset	Frequency	Severity

Current Medications (include nonprescription drugs as well. List all herbs, vitamins and supplements on page 8).

Name of Medication	Dosage (mg)	How Often?	ReasonTaken

Drug Allergies/Reactions/Sensitivities (drug, food, environment):

____

____

Vaccinations (date):

Pneumonia ______________ Hepatitis B ____________ Tetanus ________________ Rubella _______

Influenza _______________ Other ________________

Medical History
Surgeries: Date/Operation

____

____

____

Other Hospitalizations, Injuries or Illnesses:
Date/Reason

____

____

____

Illnesses (√ past and/or present)

☐	Arthritis	☐	High Cholesterol	☐	Stroke
☐	Alcoholism	☐	Kidney Disease	☐	Thyroid Disease
☐	Diabetes	☐	Liver Disease	☐	AIDS
☐	Heart Disease	☐	Lung Disease	☐	Hepatitis
☐	High Blood Pressure	☐	Stomach Ulcers	☐	Cancer (Type) __________
				☐	Other __________________

Have any of your relatives had the following? Place appropriate letter for family members in box

F = Father M = Mother S = Sister B = Brother A = Aunt U = Uncle GM = Grandmother C = Child

	No	Yes	If yes, which family member	Age at Diagnosis
Heart Disease	☐	☐		
High blood pressure	☐	☐		
Diabetes	☐	☐		
Cancer	☐	☐		
Depression	☐	☐		
Anxiety	☐	☐		
Osteoporosis	☐	☐		
Kidney disease	☐	☐		
Alcoholism/Substance abuse	☐	☐		
Headaches	☐	☐		
Inflammatory bowel disease	☐	☐		
Thyroid disease (goiter, high/low)	☐	☐		
Hay fever, asthma, eczema	☐	☐		
Seizure/epilepsy	☐	☐		
Glaucoma	☐	☐		
Anemia	☐	☐		

	Current Age	Age @ Death	Cause of Death		Current Age	Age @ Death	Cause of Death
Father				Spouse			
Mother				Children			
Brothers							
Sisters							

Social History

□ Married □ Partnered □ Single □ Divorced (year ______) □ Widowed (year _____)

Present relationship (# yrs) ________________________ Previous relationship (# yrs) __________________

Present Occupation ______________________________ yrs _____ Education ________________________

Previous Occupation _____________________________ yrs _____ Partner's Occupation _______________

Persons currently living in your home ____

Do you have a living will? □ No □ Yes (please provide copy)

Do you use tobacco? □ No (if quit, when? ________) □ Yes (how long?) _________________________

Do you want to quit? □ No □ Yes In what form do you use tobacco? ___________ How much? __________

Do you exercise? □ No □ Yes How many times a week? _________ How long? ___________________

Do you drink alcohol? □ No (If quit, when? ________) □ Yes For how many years? __________________

What do you drink? _____________________________ How much? ___________ How often? ___________

Have you ever used "street" (illegal) drugs? □ No □ Yes Intravenous Drugs? □ No □ Yes

Are you concerned about exposure to AIDS or other sexually transmitted diseases? □ No □ Yes

Have you ever been tested for HIV? □ No □ Yes (date/result _______________)

Do you want to be tested? □ No □ Yes

Have you ever been treated for drug/alcohol abuse? □ No □ Yes

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What are the major stressors in your life? ____

____

What do you do to relieve stress? ____

What do you do for fun?_ ____

What interests/hobbies do you have? ____

Do you have a spiritual or religious practice? ____

What brings you joy? ____

What is most important to you? ____

What causes the greatest challenges to you? ____

What do you do well? ____

What are your greatest fears and deepest sorrows? ____

____

Do you have any insight into your illness? ____

____

What does health mean to you? ____

____

If you could change on thing in your life, what would it be? ____

____

____

√ **Present (P) or Past as appropriate**

General

Recent weight change:
_________ lbs (gain or loss?)

Childhood/other Illnesses
P or Past
- ☐ ☐ Chicken pox
- ☐ ☐ Childhood hyperactivity
- ☐ ☐ German measles
- ☐ ☐ Measles
- ☐ ☐ Mononucleosis
- ☐ ☐ Mumps
- ☐ ☐ Polio
- ☐ ☐ Malaria
- ☐ ☐ Tuberculosis

Skin Problems

P or Past
- ☐ ☐ Eczema
- ☐ ☐ Psoriasis
- ☐ ☐ Dandruff/dry scalp
- ☐ ☐ Dry, itchy skin
- ☐ ☐ Hives or rashes
- ☐ ☐ Bruise easily
- ☐ ☐ Soft/brittle nails
- ☐ ☐ Perspire easily
- ☐ ☐ Night sweats
- ☐ ☐ Fever
- ☐ ☐ Cold sores/herpes
- ☐ ☐ Sores in mouth
- ☐ ☐ Gum problems
- ☐ ☐ Grinding teeth
- ☐ ☐ Cold hands, and feet

Blood

P or Past
- ☐ ☐ Anemia
- ☐ ☐ Easy bruising/bleeding
- ☐ ☐ Blood transfusion(s)
- ☐ ☐ Swollen glands
- ☐ ☐ Leukemia
- ☐ ☐ Heat or Cold Intolerance
- ☐ ☐ Positive TB skin test
- ☐ ☐ Thyroid Disorder
- ☐ ☐ Blood Transfusion When? ________

Head and Neck

P or Past
- ☐ ☐ Change in vision
- ☐ ☐ Eye infections
- ☐ ☐ Floaters
- ☐ ☐ Double vision
- ☐ ☐ Cataracts
- ☐ ☐ Glaucoma
- ☐ ☐ Hearing loss
- ☐ ☐ Ringing in ears
- ☐ ☐ Frequent nosebleeds
- ☐ ☐ Nasal/sinus congestion
- ☐ ☐ Sore throat
- ☐ ☐ Persistent hoarseness
- ☐ ☐ Tonsilitis
- ☐ ☐ Goiter
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Loss of Smell
- ☐ ☐ Neck Lumps
- ☐ ☐ Tearing

Heart and Circulation

P or Past
- ☐ ☐ Tightness/pain in chest
- ☐ ☐ Palpitations
- ☐ ☐ Ankle/foot swelling
- ☐ ☐ Heart murmur
- ☐ ☐ Rheumatic fever
- ☐ ☐ High blood pressure
- ☐ ☐ Varicose veins/phlebitis
- ☐ ☐ Shortness of breath when lying down
- ☐ ☐ Leg pain with walking
- ☐ ☐ Heart disease list: ____________________________________

Lungs

P or Past
- ☐ ☐ Daily cough
- ☐ ☐ Blood in sputum
- ☐ ☐ Allergies
- ☐ ☐ Exposure to TB
- ☐ ☐ Bronchitis
- ☐ ☐ Hay Fever
- ☐ ☐ Wheezing/asthma
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia
- ☐ ☐ Pleurisy
- ☐ ☐ Shortness of breath
- ☐ ☐ Loud snoring
- ☐ ☐ Falling asleep while working

Nervous System

P or Past
- ☐ ☐ Migraine/headache
- ☐ ☐ History of head injury
- ☐ ☐ Dizziness
- ☐ ☐ Seizures/convulsions
- ☐ ☐ Numbness/tingling
- ☐ ☐ Paralysis
- ☐ ☐ Stroke
- ☐ ☐ Weakness
- ☐ ☐ Tremors/shakes
- ☐ ☐ Difficulty with memory
- ☐ ☐ Difficulty with writing
- ☐ ☐ Difficulty with walking
- ☐ ☐ Difficulty with speaking
- ☐ ☐ Tired upon awakening
- ☐ ☐ Insomnia
- ☐ ☐ Difficulty sleeping
- ☐ ☐ Nightmares/vivid dreams
- ☐ ☐ Depression/unhappiness
- ☐ ☐ Crying spells
- ☐ ☐ Trouble concentrating
- ☐ ☐ Exhaustion/fatigue
- ☐ ☐ A wish to be dead and away
- ☐ ☐ Nervousness/anxiety
- ☐ ☐ Panic attacks
- ☐ ☐ Stress
- ☐ ☐ Nervous breakdown
- ☐ ☐ Seasonal Allergies

√ **Present (P) or Past as appropriate**

Bones and Joints

P or Past

☐ ☐ Arthritis
☐ ☐ Joint Pain
☐ ☐ Swollen joints
☐ ☐ Red or warm joints
☐ ☐ Joint Stiffness
☐ ☐ Back pain/injury
☐ ☐ Sciatic pain
☐ ☐ Scoliosis
☐ ☐ Gout
☐ ☐ Osteoporosis
☐ ☐ Rheumatism
☐ ☐ Morning joint stiffness

Stomach and Bowels

P or Past

☐ ☐ Decreased appetite
☐ ☐ Hypoglycemia
☐ ☐ Nausea/vomiting
☐ ☐ Heartburn/indigestion
☐ ☐ Abdominal pain/bloating
☐ ☐ Use antacids
☐ ☐ Belching
☐ ☐ Flatulence (gas)
☐ ☐ Ulcers
☐ ☐ Gallbladder disease
☐ ☐ Gallstones
☐ ☐ Change in bowel habits
☐ ☐ Diarrhea
☐ ☐ Frequent loose stools
☐ ☐ Constipation
☐ ☐ Black or bloody stools
☐ ☐ Hemorrhoids
☐ ☐ Colon problems/colitis
☐ ☐ Jaundice/hepatitis
☐ ☐ Anorexia/bulimia
☐ ☐ Hiatal hernia
☐ ☐ Poor eating habits

Kidneys and Bladder

P or Past

☐ ☐ Hernia in groin
☐ ☐ Blood in urine
☐ ☐ Kidney stones
☐ ☐ Nighttime urination
_____x per night
☐ ☐ Frequent daytime urination
☐ ☐ Stream weak/slow
☐ ☐ Difficulty starting stream
☐ ☐ Discomfort on urination
☐ ☐ History of urinary infection
☐ ☐ Loss of bladder control
☐ ☐ Loss of sexual interest
☐ ☐ History of venereal disease
☐ ☐ Practice Birth Control
Method_________________
Sex satisfactory Yes/No

Men

P or Past

☐ ☐ Penile sores or discharge
☐ ☐ Testicular pain/lumps
☐ ☐ Impotence
☐ ☐ History of venereal disease
☐ ☐ Herpes
☐ ☐ Prostate infection/enlarged
☐ ☐ Burning urination
☐ ☐ Dribbling urination
☐ ☐ Nocturnal emission
☐ ☐ Vasectomy

Women

P or Past

☐ ☐ Irregular periods
☐ ☐ Severe menstrual cramps
☐ ☐ Vaginal spotting
☐ ☐ Heavy menstrual flow
☐ ☐ Clotting
☐ ☐ Vaginal discharge
☐ ☐ Itching
☐ ☐ Hot flashes
☐ ☐ Pain with intercourse
☐ ☐ Bleeding with intercourse
☐ ☐ Yeast infection
☐ ☐ Genital burning
☐ ☐ Herpes
☐ ☐ Infertility
☐ ☐ Ovarian cyst
☐ ☐ Uterine fibroids
☐ ☐ Age of menopause ____
☐ ☐ Complications of pregnancy
☐ ☐ Pelvic inflammatory disease
☐ ☐ Tubal ligation
☐ ☐ PMS-physical
☐ ☐ PMS-emotional

Breast

☐ ☐ Lumps in breasts
☐ ☐ Nipple discharge
☐ ☐ Had mammogram
Date of last exam
____

Menstrual History

Age @ onset ___________________
Last period ____________________
days between periods ___________
days period lasts _____________
Cycles Regular? ________________
Last pap ______________________
Circle: Normal/abnormal
Number of pregnancies __________
Number of miscarriages __________
Number of abortions _____________
Birth control pill
Circle: Yes/No

Health Maintenance

Examination

Examination		If yes, when? Month/Year			If yes, when? Month/Year
Pap/pelvic exam (females)	□ Yes □ No	____________	Mammogram (females)	□ Yes □ No	____________
Prostate Specific Antigen (Male)	□ Yes □ No	____________	Blood pressure check	□ Yes □ No	____________
Urinalysis	□ Yes □ No	____________	Chest x-ray	□ Yes □ No	____________
Cardiovascular stress test	□ Yes □ No	____________	Glaucoma screening	□ Yes □ No	____________
Eye Exam	□ Yes □ No	____________	Flexible sigmoidoscopy	□ Yes □ No	____________
Colonoscopy	□ Yes □ No	____________	Test of stool for blood	□ Yes □ No	____________
Bone density test (Dexa Scan)	□ Yes □ No	____________			

Sleep

How many hours sleep do you average? _________ Do you ever have trouble falling asleep? _______________

Do you feel rested when you awaken? □ Yes □ No Do you feel tired or irritable during the day? __________________

Do you ever wake up during the night and can't fall back to sleep? □ Yes □ No

Has your partner ever complained that you snore? □ Yes □ No Do you take naps during the day? □ Yes □ No

Safety

Do you use regular sunscreen? □ Yes □ No If yes, what brand? _______________________________

Do you routinely wear a seatbelt? □ Yes □ No What time of day is your energy the best? ______ the worst? ______

Support

Do you enjoy your work? _________________ Do you take vacations? ______________________

Friends/support network ____

Have you ever seen a psychotherapist? If so, please explain: ____

____

____

What have been the pivotal events in your life? ____

____

____

____

What are your health and lifestyle goals for the present and for the next 3-5 years? __________________________________

____

____

____

____

Nutrition Evaluation Food Diary

Please list all foods and drinks that you have consumed in the previous 24 hours. Included meals, snack, beverages and condiments.

Food Item How Prepared (baked, Fried, Etc.)

____

____

____

____

____

____

____

Is this a typical day? Please describe.

____

____

____

How many servings of fruit do you eat/drink each day? ______ (serving = 1 small piece fruit, 12/ cup juice, ½ cup canned/chopped fruit or ¾ dried fruit)

How many servings of vegetables do you consume each day? ______ (serving = ½ cup raw/cooked, 1 cup fresh green leafy, ¼ cup dried)

What are your sources of protein? ______________________________

Are you currently on a special diet? If yes, please explain. ______________________________

____

____

What type of oil or spreads do you add to your food? ______________________________

What kind of oil do you cook with? ________________________ Do you eat refined sugar? □ Yes □ No

Do you salt your food? □ Yes □ Heavily □ Moderately □ Not at all

Who prepares your meals? ____________________________ How often do you eat out? ____________

How often do you eat fast food? ____________________ Do you drink coffee? □ Yes. How much? ___ □ No

How would you describe your relationship with food? ______________________________

____

____

Do you drink black/green tea? □ Yes. How much? ___ □ No

Do you drink cola or other sodas? □ Yes. How much? ___ □ No

How many glasses of water do you drink a day? Do you drink □ tap □ spring □ well □ filtered □ distilled

Vitamins and Supplements

What vitamins/minerals/supplements are you taking now? Please bring all of your supplements and medications to your first appointment.

Brand or Other Name (Manufacturer)	***Reason***	***When Started***	***Dosage per day***
Example – St. John's Wort (Nature's Way	Feeling down	2 months ago	2 capsules