My Body 4 Life
Cellular rejuvenation is the key to life

HEALTH HISTORY QUESTIONNAIRE

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
All information is strictly confidential.

General Patient Information

Date: _____ / _____ / _____

Name: _____

Address: _____

City, State, Postal Code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell: Phone: (_____) _____ E-Mail: _____

Age: _____ Date of Birth: _____ / _____ / _____ Marital Status: ☐ M ☐ S ☐ D ☐ W

In Case of Emergency, Contact: _____ Phone No.: _____

Guardian (if under 18): _____

Gender: ☐ M ☐ F Height: ____ ' _____ " Weight: _____ lbs. Occupation: _____

How did you hear about our office? _____

Major Complaint(s), in order of significance to you:

1. _____ 4. _____

2. _____ 5. _____

3. _____ Additional: _____

How do these conditions impair your daily activities?

_____

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II. **Patient Medical History**

How was your childhood health? _____

Hospital Visits/Stays: _____

Recent tests: (please indicate test results and date below)

- ☐ Physical
- ☐ Cholesterol
- ☐ Prostate
- ☐ Blood (which?) _____
- ☐ HIV/STD
- ☐ Pap smear
- ☐ Mammography
- ☐ Other: _____

Test Results and Date: _____

Check any you have had in the past:

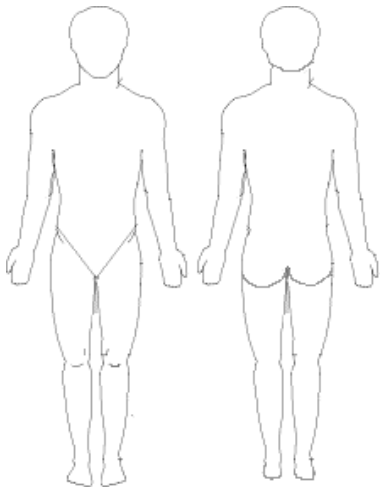
- ☐ Diabetes
- ☐ Allergies
- ☐ Glaucoma
- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ CVA (stroke)
- ☐ Vein condition
- ☐ Thyroid disorder
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Jaundice
- ☐ Gonorrhea
- ☐ Mumps
- ☐ Bleeding tendency
- ☐ Syphilis
- ☐ Measles
- ☐ Chicken pox
- ☐ Nervous disorder
- ☐ Meningitis
- ☐ HIV
- ☐ Polio
- ☐ Mononucleosis
- ☐ Epilepsy
- ☐ High fever
- ☐ Hepatitis
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Cancer
- ☐ Migraines
- ☐ High blood pressure
- ☐ Other lung illnesses
- ☐ Other liver illnesses
- ☐ Other heart illnesses
- ☐ Other kidney illness
- ☐ Other: _____

Immunizations: _____

Surgeries: _____

III. **Patient Profile**

After printing, please clearly mark any areas of pain and any scars:



Is the pain:

- ☐ Sharp
- ☐ Burning
- ☐ Aching
- ☐ Cramping
- ☐ Dull
- ☐ Moving
- ☐ Fixed
- ☐ Other: _____

Does the following lessen the pain?

- ☐ Pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Other: _____

Does the following worsen the pain?

- ☐ Pressure
- ☐ Cold
- ☐ Heat
- ☐ Other: _____

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Family Medical History (Cancer, Diabetes, Heart Disease, High Blood Pressure, Stroke, etc.)

Father: _____

Mother: _____

Sibling(s): _____

Patient Signature: _____

Date: _____