



# Healing Pathways Medical Clinic

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## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are optional, strictly confidential and will become part of your medical record.

<b>Name</b> (Last, First, M.I.):			<b>Today's Date</b>	
<b>Address</b> (Street): (City, State, Zip):			M F	<b>Age:</b>
			<b>Date of birth</b>	
<b>Email:</b>			<b>Occupation</b>	
<b>Phone:</b>	Home:	Work:	<b>Employer</b>	
<b>Marital Status:</b>	Single Partnered Married Separated Divorced Widowed			
<b>Children</b> (Names, Ages)				
<b>Name of Significant Other:</b>				
<b>Previous or referring doctor:</b>	<b>Date of last physical exam:</b>			
<b>How did you hear about me?</b>				

Reason for visit, listed in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Please list any medical problems that other physicians have diagnosed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe your interests, hobbies, spiritual practices, things you do to relax \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medication allergies (including reaction when taken): \_\_\_\_\_  
 \_\_\_\_\_

Please list ALL medicines, prescribed and over the counter (OTC), including vitamins, herbs, homeopathics, Etc. or check [ ] if you do not take medicine regularly.

Medicine	Strength	Times/Day	Reason	Prescriber

Family Health History					
	Age	Significant Health Problems		Age	Significant Health Problems
<b>Father</b>					
<b>Mother</b>					
<b>Sibling</b>			M F		
			M F		
			M F	<b>Grandmother</b> Maternal	
			M F	<b>Grandfather</b> Maternal	
			M F	<b>Grandmother</b> Paternal	
			M F	<b>Grandfather</b> Paternal	

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Last, First MI

Surgeries/Hospitalizations		
Year	Reason	Hospital

Health Habits and Personal Safety						
Exercise	<input type="checkbox"/> Sedentary (no exercise)					
	<input type="checkbox"/> Mild exercise (e.g., climb stairs, walk three blocks, golf)					
	<input type="checkbox"/> Occasional vigorous exercise (e.g., work or recreation, less than 4x/week for 30 minutes each time)					
	<input type="checkbox"/> Regular vigorous exercise (e.g., work or recreation, at least 4x/week for 30 minutes each time)					
Diet	Number of meals you eat in an average day? _____					
<i>Typical Day's Diet</i>	Breakfast: _____					
	Lunch: _____					
	Dinner: _____					
	Snacks: _____					
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee, # cups per day _____		<input type="checkbox"/> Tea, # of cups per day _____		<input type="checkbox"/> Cola, # of cans per day _____
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many drinks per week? _____		
	Are you concerned about the amount you drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you considered stopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Drive after drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you prone to binge drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cigarettes, pks/day _____	Chew, _____	Cigars, #/day _____
Illegal Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, which kinds and how often? _____	
Sex	Are you sexually active?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, are you trying for pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not trying for a pregnancy, list contraception method used _____			Any discomfort with intercourse?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	With whom do you live? _____		
	Physical and/or mental abuse have become major public health issue in this country. This often take the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this with the doctor?				<input type="checkbox"/> Yes <input type="checkbox"/> No	

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Last, First MI

Mental Health		
Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic (anxiety) when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Review of Systems	
Weight	Present weight: _____ Weight one month ago: _____ Weight one year ago: _____
	Maximum weight and when: _____ Minimum weight as adult and when: _____
Height	Your current height: _____

**REGARDING THE NEXT LONG SECTION:** Please circle (Y) if you have the problem CURRENTLY, (N) if you have NEVER had the problem and (P) if you had the problem in the PAST.

Good energy:            Y      N      P

Fatigue:                Y      N      P

If you have fatigue, when does it affect you most, morning, afternoon, and/or evening? \_\_\_\_\_

SKIN

Rash:                    Y      N      P  
 Hives:                   Y      N      P  
 Psoriasis:              Y      N      P  
 Eczema:                Y      N      P  
 Dry:                      Y      N      P  
 Cancer of skin:        Y      N      P

Color change:        Y      N      P  
 Lump:                    Y      N      P  
 Itchy:                    Y      N      P  
 Warts/moles:         Y      N      P  
 Perspiration:         Y      N      P

HEAD

Headache:             Y      N      P  
 Dandruff:              Y      N      P  
 Oily hair:              Y      N      P  
 Dry hair:                Y      N      P

Migraine:              Y      N      P  
 Head injury:          Y      N      P  
 Hair loss:               Y      N      P

NOSE

Frequent colds:        Y      N      P  
 Congestion:            Y      N      P  
 Polyps:                  Y      N      P

Nosebleeds:            Y      N      P  
 Post nasal drip:        Y      N      P  
 Seasonal allergies:    Y      N      P

EYES

Dry eyes:                Y      N      P  
 Watery eyes:            Y      N      P  
 Double vision:         Y      N      P  
 Glaucoma:               Y      N      P  
 Eye strain:              Y      N      P

Itchy:                    Y      N      P  
 Blurry vision:          Y      N      P  
 Cataracts:               Y      N      P  
 Discharge:              Y      N      P  
 Dark under eyelids:    Y      N      P

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Last, First MI

**MOUTH/THROAT**

Canker sores:	Y	N	P	Cold sores (fever blisters):	Y	N	P
Sore throat:	Y	N	P	Gum disease:	Y	N	P
Dentures:	Y	N	P	Cavities:	Y	N	P
Loss of taste:	Y	N	P	Hoarseness:	Y	N	P
Difficulty swallowing:	Y	N	P				

**NECK**

Stiffness:	Y	N	P	Tension:	Y	N	P
Swollen glands:	Y	N	P				

**RESPIRATORY**

Cough:	Y	N	P	Wheezing:	Y	N	P
Shortness of breath with exertion:	Y	N	P	TB:	Y	N	P
Shortness of breath when sitting:	Y	N	P	Bronchitis:	Y	N	P
Shortness of breath when lying down:	Y	N	P	Pneumonia:	Y	N	P
				Asthma:	Y	N	P
				Painful breathing:	Y	N	P

**CARDIOVASCULAR**

High blood pressure:	Y	N	P	Rheumatic fever:	Y	N	P
Low blood pressure:	Y	N	P	Murmurs:	Y	N	P
Arrhythmias:	Y	N	P	Palpitations:	Y	N	P
Edema:	Y	N	P	Chest pain:	Y	N	P

**GASTROINTESTINAL**

Heartburn:	Y	N	P	Bowel movement frequency: _____			
Indigestion:	Y	N	P	Recent BM change:	Y	N	P
Bloating:	Y	N	P	Diarrhea:	Y	N	P
Nausea:	Y	N	P	Constipation:	Y	N	P
Vomiting:	Y	N	P	Hemorrhoids:	Y	N	P
Change in appetite:	Y	N	P	Liver/gall bladder disease:	Y	N	P
Pancreatitis:	Y	N	P	Ulcer:	Y	N	P

**MUSCULOSKELETAL**

Weakness:	Y	N	P	Arthritis:	Y	N	P
Stiffness:	Y	N	P	Leg cramps:	Y	N	P
Tremors:	Y	N	P	Pain:	Y	N	P

**NERVOUS**

Paralysis:	Y	N	P	Sciatica:	Y	N	P
Tingling/numbness:	Y	N	P	Carpal tunnel syndrome:	Y	N	P
Seizures:	Y	N	P	Fainting:	Y	N	P

**URINARY TRACT**

Incontinence:	Y	N	P	Pain with urination:	Y	N	P
Frequent infections:	Y	N	P	Kidney stones:	Y	N	P
Urgency:	Y	N	P	Discharge/blood:	Y	N	P

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

DOB: \_\_\_\_\_

Last, First MI

**MALE GENITALIA**

Testicular pain/swelling: Y N P  
 STD: Y N P  
 Hernia: Y N P

Discharge: Y N P  
 Impotency: Y N P  
 Prostate disease: Y N P

**FEMALE GENITALIA**

Age period began: \_\_\_\_\_  
 How long period lasts: \_\_\_\_\_  
 Menstrual cramping: Y N P  
 PMS: Y N P  
 Number of pregnancies: \_\_\_\_\_  
 Number of births: \_\_\_\_\_  
 Number of miscarriages: \_\_\_\_\_  
 Last pap smear: \_\_\_\_\_  
 Any abnormal paps: Y N P  
 Menopause since what age: \_\_\_\_\_  
 Hormone replacement: Y N P  
 Please list any birth control usage including ages used: \_\_\_\_\_

How often period occurs: \_\_\_\_\_  
 Heavy menstrual bleeding: Y N P  
 Menstrual pain: Y N P  
 Food cravings: Y N P  
 Healthy libido: Y N P  
 Vaginitis: Y N P  
 Mammography: Y N P  
 Vaginal dryness: Y N P  
 Pain with intercourse: Y N P  
 STD: Y N P

**MENTAL/EMOTIONAL**

Depression: Y N P  
 Suicidal: Y N P  
 Anxiety: Y N P  
 Eating disorder: Y N P

Anger/irritability: Y N P  
 Tense: Y N P  
 Fear/panic: Y N P  
 Psyc hospitalization: Y N P

**SLEEP**

How long per night: \_\_\_\_\_  
 Nightmares: Y N P  
 Sleep walk: Y N P  
 Must nap during day: Y N P

If you wake frequently, what is the reason? \_\_\_\_\_

Wake refreshed: Y N P  
 Grind teeth: Y N P  
 Snore: Y N P

Please include any concerns you have that have not been asked above, here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNATURE:** The information provided above is correct to the best of my knowledge:

\_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Thank you for taking the time to thoughtfully and completely answer the above questions!  
 This is the first step towards better health!