

**PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN ONE WEEK BEFORE YOUR APPOINTMENT. SHALL WE CALL YOU IF AN APPOINTMENT IS AVAILABLE BEFORE YOUR SCHEDULED APPOINTMENT? \_\_\_\_\_**

<b>IDENTIFICATION DATA</b>		<b>PLEASE PRINT</b>		Today's Date _____	
Patient's Last Name _____	First Name _____	Initial _____	Date of Birth _____	Male <input type="checkbox"/>	Female <input type="checkbox"/>
			<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single		
Address _____			Education: _____ years Elementary _____ years High School		
City _____ State _____ Zip _____			_____ years College, Technical, Business, etc.		
Home Telephone (____) _____ - _____			Occupation _____		
Business Telephone (____) _____ - _____			Height _____ Weight _____		
			Medicare or Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Indicate which ailments affected your relatives. List their ages even if they are/were healthy. Ailments to consider:** A.I.D.S., Alcoholism, Allergies, Arthritis, Asthma, Bowel Problems, Cancer, Diabetes, Emotional Problems, Frequent Colds, Genetic Diseases, Gonorrhoea, Gout, Hay Fever, Headaches, Heart Problems, High Blood Pressure, Hypoglycemia, Irritability, Kidney Ailments, Menstrual Problems, Mental Illness, Nervous Breakdown, Obesity, Ovary Problems, Paralysis, Pleurisy, Pneumonia, Seizures, Skin Problems, Syphilis, Thyroid Problems, Tuberculosis, Tumors, Ulcers, Warts, and **any other problems you know of in your family.**

	AGE IF ALIVE	AGE AT DEATH	AILMENTS
Father			
Mother			
Brothers			
Sisters			
Maternal Grandfather			
Maternal Grandmother			
Maternal Aunts/Uncles			
Paternal Grandfather			
Paternal Grandmother			
Paternal Aunts/Uncles			

<u>HOSPITALIZATIONS and/or SURGERY</u>	<u>DATE</u>	<u>REASON WHY</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMAIL: _____	Referred By _____
Name and Address of Nearest Relative or Friend (in Case of Emergency):	
Name _____	Relationship _____
Address _____	Telephone _____
If patient is a child, give parents' names _____	

**PAYMENT IS EXPECTED AT THE TIME OF SERVICE. THANK YOU**



Which of the following have you had?

*(Please Circle)*

DATE OF ILLNESS

CAUSE, IF KNOWN

/

TREATMENT

Abscesses

Acne

Alcoholism

Allergies (including drugs)

Anemia

Appendicitis

Arthritis

Asthma

Back or Neck Strain

Baldness

Bed Wetting

Bladder Infections (cystitis)

Bleeding Tendency

Boils

Bronchitis

Cancer (including skin)

Cataracts

Chicken Pox

Cirrhosis - Liver

Colds - Recurrent

Colitis

Concussion

Congenital Defect

Constipation

Dandruff

Depression

Dizziness

Diabetes

Diarrhea - Chronic

Diphtheria

Diverticulitis/Diverticulosis

Dysentery

Ear Infections - Recurrent

Eczema

Emphysema

Epilepsy

Fibrocystic Breasts

Fissures

Fistula

Which of the following have you had?  
(Please Circle)

	DATE OF ILLNESS	CAUSE, IF KNOWN	/	TREATMENT
Fractures	_____	_____		_____
Gallbladder Problem (What Kind?)	_____	_____		_____
Glaucoma	_____	_____		_____
Goiter	_____	_____		_____
Gonorrhea	_____	_____		_____
Gout	_____	_____		_____
Hay Fever	_____	_____		_____
Headaches - Recurrent	_____	_____		_____
Hearing Impairment	_____	_____		_____
Heartburn	_____	_____		_____
Heart Disease	_____	_____		_____
Hemorrhoids	_____	_____		_____
Hepatitis	_____	_____		_____
Hernia - Specify Location	_____	_____		_____
Herpes - Specify Type/Location	_____	_____		_____
High Blood Fats - Cholesterol	_____	_____		_____
High Blood Pressure	_____	_____		_____
H.I.V. Positive	_____	_____		_____
Impetigo	_____	_____		_____
Infectious Mononucleosis	_____	_____		_____
Ingrown Toenails	_____	_____		_____
Injuries, Serious	_____	_____		_____
Irritability	_____	_____		_____
Kidney Disease/Infection	_____	_____		_____
Learning Disability	_____	_____		_____
Malaria	_____	_____		_____
Measles - Specify Type	_____	_____		_____
Meningitis	_____	_____		_____
Menstrual Problems / PMS	_____	_____		_____
Mental Illness	_____	_____		_____
Mumps	_____	_____		_____
Nervous Breakdown	_____	_____		_____
Nosebleeds	_____	_____		_____
Obesity	_____	_____		_____
Osteoporosis	_____	_____		_____
Ovarian Cyst or Tumor	_____	_____		_____
Paralysis/Neurological Problems	_____	_____		_____
Parasitic Infection	_____	_____		_____
Pelvic Infection	_____	_____		_____

Which of the following have you had?

*(Please Circle)*

DATE OF ILLNESS

CAUSE, IF KNOWN

/

TREATMENT

Phlebitis

Pneumonia

Poison Ivy or Oak Sensitivity

Polyps (Specify Location)

Prostate Problems (What kind?)

Psoriasis

Regional Ileitis (Crohn's Disease)

Rheumatic Fever

Rheumatism

Ringworm

Root Canal Surgery

Scarlet Fever

Sexual Problems

Shingles

Silicone Implants

Skin Problems (What kind?)

Sore Throats - Recurrent

Stool Change, Blood, etc.

Stroke (Apoplexy)

Styes

Suicide Thoughts or Attempt

Syphilis

Thyroid Problem (What kind?)

Tuberculosis

Tumors

Ulcers - Specify Location

Urination Problem

Uterine Problem (Fibroids, etc.)

Vaginitis - Recurrent

Varicose Veins

Visual or Eye Problems

Warts - Specify Location

Weight Loss - Unexplained

Whooping Cough

BIRTH HISTORY: Place of Birth \_\_\_\_\_ Home \_\_\_\_\_ Hospital \_\_\_\_\_ Other \_\_\_\_\_

How was the health of your mother during her pregnancy with you? \_\_\_\_\_

What were the complications of your mother's labor and delivery? \_\_\_\_\_

Your Birth Weight? \_\_\_\_\_ Height/Length? \_\_\_\_\_

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Have you been exposed to chemicals, pesticides, etc.? How did they affect you?

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How many mercury amalgam (silver-colored) dental fillings do you have in your mouth?

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For Women: Number of pregnancies: \_\_\_\_\_

Number of children: \_\_\_\_\_ How many breast fed? \_\_\_\_\_

Number of spontaneous miscarriages: \_\_\_\_\_

Number of voluntary abortions: \_\_\_\_\_

Other (explain): \_\_\_\_\_

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List your children's names, ages, and ailments:

CHILDREN'S NAMES

AGES

HEALTH PROBLEMS

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How is the health of your spouse or partner? What ailments does s/he have?

What is your spouse's/partner's occupation?

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How much do/did you smoke? When and for how long?

How much alcohol do/did you drink? When and for how

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What do you do in your spare time? Hobbies?

Do you exercise regularly? How much? How Often?

PLEASE LIST EVERYTHING THAT YOU EAT OR DRINK FOR THREE FULL DAYS.

Day One

Day Two

Day Three

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Breakfast

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Lunch

---

Supper

---

Snacks

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DO YOU WANT DIETARY ADVICE?    Yes        No

**IMMUNIZATION RECORD**

Which immunizations have you had? Give dates. What reactions did they cause?

Please make a photocopy for yourself  
and return this questionnaire to

COREhealth

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