

Dr. Morrison's Medical Health History Questionnaire

Name: _____ Date: _____

Please list the most important reason(s) you came in today:

What other health concerns do you have at this time?

Please list other doctors, chiropractors, acupuncturists and physical therapists you see and for what:

Medical History (Please include dates):

Major illnesses:

Surgeries:

List prescription medicine you now take (include dosage, reason you take it):

List over-the-counter medicines, vitamins, and food supplements you take and why?:

Anaphylactic Reactions or severe reactions (medications, food, stings) to:

Sensitivities (medication, supplements, foods, etc.)

Has anyone in your family had and who?

Alcoholism Arthritis Asthma Cancer: type _____

Glaucoma Diabetes Heart disease Genetic disorder

Mental illness Stomach problems Thyroid disease Tuberculosis

Please mark "N" for problems that you NOW have, a "T" for problems you are being treated for and "P" for any PAST problems:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Drug addiction <input type="checkbox"/> | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Hearing trouble | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> STDs | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Trauma, major | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Urinary infections |
| <input type="checkbox"/> Vision trouble | <input type="checkbox"/> Ulcer <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Herpes | |
| <input type="checkbox"/> Hypertension | | | |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Memory trouble | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Neurosis/psychosis | <input type="checkbox"/> Psoriasis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> Other _____ | | | <input type="checkbox"/> |

Recent Medical Care: Where did you last receive medical care? _____

For what reason(s)? _____

Date of last physical exam: _____ Date of last EKG: _____

Date of last TB test: _____ Date of last rectal exam: _____

Date of last lab work: _____ Date of last tetanus shot: _____

Men:

Date of last prostate exam: _____ Have you had a vasectomy? _____

Date of last colonoscopy? _____

Women:

Age of 1st period _____ First day of last normal period _____

of pregnancies _____ # of live births _____ # of children living with you _____

Birth control method _____ Date of last pap _____

Done where _____

Date of last mammogram _____ Done where? _____

Date of last bone densitometry (dexa)? _____ Last colonoscopy? _____

Do/did you have? Abnormal mammogram Abnormal pap smear

Bad menstrual cramps Heavy periods Hot flashes Infertility

Irregular periods PMS Menopause Vaginal dryness

Vaginal discharge Vaginal odor Vaginal itching

Pelvic pain Breast problems

ALL:

Any issues with lungs or breathing? _____

Any issues with urination or kidneys? _____

Do you have any skin issues or concerns? _____

Do you have any bone, muscle, or joint problems? If so, please describe them: _____

Do you have any strength, sensation, coordination, or neurological function problems? If so, please describe them: _____

Do you have any sexual concerns? _____

Do you have any hormonal concerns (adrenal, thyroid, blood sugar, sexual)? _____

Do you have any problems with thinking, concentration, mood, energy level, or interest in life? If so, please describe them: _____

Do you have any digestion problems, or any concerns with your stomach, intestines, colon, or bowel movements? If so, please describe them: _____

Diet (mark N now and P for past):

Junk food Standard American (meat, potatoes, desert) Wholesome

Raw foods Vegetarian

What do you typically eat for breakfast and when?

What do you typically eat for lunch and when?

What do you typically eat for dinner and when?

What do you generally snack on and when?

What do you typically drink during the day?

Height? _____ **Weight?** _____ How much would you like to weigh? _____

Hobbies:

Exercise: What, and how often?

Sleep: How many hours? ____ Light ____ Sound ____ Insomnia ____ #
waking's _____

Do/did you smoke? yes no How much? _____ packs/day _____
years _____ year quit? _____ chewing tobacco

Do/did you consume alcohol? yes no How much? _____ Do you want to quit? ____

Do/did you use:

Caffeine Coffee _____ Tea green & black _____ Sodas _____

Nutrasweet/other artificial sweetner margarine diet pills

marijuana cocaine Other _____

Anything Else? _____

Patient signature _____ Date _____

Thank you for taking the time to provide this information so that we may provide you with more effective care.

