CENTER FOR HEALTH
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NUTRITIONAL HEALTH HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____
Address: _____
Phone: Home: _____ Cell: _____Work: _____Email: _____
Social Security #: _____Sex: ☐M ☐F Date of Birth: _____ Marital Status: _____
Occupation: _____ Number of Children: _____
Patient's Employer/School: _____ Phone: _____
Employer/School Address:
_____
_____
Spouse's Name: _____ Birthdate: _____
Spouse's Employer: _____ Social Security #: _____
Best time and place to reach you? _____
Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT:
Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Place a mark indicating if you have had any of the following with a "Yes" or "No".

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV			Diabetes			Liver Disease			Psychiatric Care		
Alcoholism			Emphysema			Measles			RheumatoidArthritis		
Anemia			Epilepsy			Migraine Headache			Rheumatic Fever		
Anorexia			Fractures			Miscarriage			Scarlet Fever		
Appendicitis			Glaucoma			Mononucleosis			Sexually Tran Dis		
Arthritis			Goiter			Multiple Sclerosis			Stroke		
Asthma			Gonorrhea			Mumps			Suicide Attempt		
Bleeding Disorders			Gout			Osteoporosis			Thyroid Problems		
Breast Lump			Heart Disease			Pacemaker			Tonsillitis		
Bronchitis			Hepatitis			Parkinsons Disease			Tuberculosis		
Bulimia			Hernia			Pinched Nerve			Tumors, Growths		
Cancer			Herpes			Pneumonia			Typhoid Fever		
Cataracts			High Blood Pressu			Polio			Ulcers		
Chemical Dependent			High Cholesterol			Prostate Problem			Vaginal Infection		
Chicken Pox			Kidney Disease			Liver Disease			Whooping Cough		

Date of last Physical Exam: _____ Date of last X-Ray/CT Scan/MRI _____

REASON FOR VISIT

Chief Complaint #1 _____

Chief Complaint #2 _____

Chief Complaint #3 _____

When did your symptoms first appear? _____

Is your condition getting worse? Yes No Constant Comes and goes

Rate the severity of your complaint(s):

On a scale of 1 (least severe) through 10 (most severe) rate your above complaints.

#1	___/10	Daily	Constant	A few times/wk	1-2x/month
#2	___/10	Daily	Constant	A few times/wk	1-2x/month
#3	___/10	Daily	Constant	A few times/wk	1-2x/month

Do they interfere with your? Work Sleep Recreation Daily Routine Other

What treatment have you already received for your condition?

_____
_____
_____

Name and address of other doctor(s) who have treated you for your condition:
1. _____
2. _____
3. _____

DAILY LIVING

Exercise:	None	Moderate	Daily	Heavy
Work Activity:	Sitting	Standing	Light labor	Heavy Labor
Habits:	Smoking: Packs/Day ____		Alcohol: Drinks/Week ____	
	Coffee/Caffeine: Cups/Day _____			

High Stress Level?
Reason _____
_____
Are You Pregnant? No Yes Date Due:_____