



**Dr. Pea's Active Health Center**  
**Health History Questionnaire**  
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Please allow ample time to complete your health history form. Some of the questions that follow may seem unrelated to your condition, however they may play a major role in your diagnosis and treatment.

*All information is strictly confidential.*

**I. General Patient Information**

Date: \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: (\_\_\_\_) \_\_\_\_\_ Work Ph: (\_\_\_\_) \_\_\_\_\_ Cell Ph: (\_\_\_\_) \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Place of Birth: \_\_\_\_\_

Email address: \_\_\_\_\_ Guardian (if under 18): \_\_\_\_\_

Gender:  M  F Height: \_\_\_'\_\_\_" Weight: \_\_\_\_\_lbs. Social Security # : \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Do you have health insurance? \_\_\_\_\_ Name of Insurance Co. \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Verification Ph. # ( ) \_\_\_\_\_ - \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Person to notify in event of emergency (Name & Ph): \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Does anything limit you from pursuing care?  Y  N If yes, explain: \_\_\_\_\_

Other physicians/therapists seen for this condition: \_\_\_\_\_

\_\_\_\_\_

Medications (if any): \_\_\_\_\_

\_\_\_\_\_

Treatment(s): \_\_\_\_\_

\_\_\_\_\_

Results: \_\_\_\_\_

\_\_\_\_\_

Supplements: (vitamins, herbs, etc.): \_\_\_\_\_

\_\_\_\_\_

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

Severe   Moderate   Slight

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	How long? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	How long? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	How long? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	How long? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	How long? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	How long? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	How long? _____

How do these conditions impair your daily activities? \_\_\_\_\_

**II. Patient Medical History**

How was your childhood health? \_\_\_\_\_

Hospital Visits/Stays: \_\_\_\_\_

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

<input type="checkbox"/> Physical	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Prostate	<input type="checkbox"/> Blood
<input type="checkbox"/> HIV/STD	<input type="checkbox"/> Pap smear	<input type="checkbox"/> Mammography	<input type="checkbox"/> Other: _____

Test Results and Date: \_\_\_\_\_

Check any you have had in the past:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> CVA (stroke)	<input type="checkbox"/> Vein condition	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mumps	<input type="checkbox"/> Bleeding tendency
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Measles	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Nervous disorder
<input type="checkbox"/> Meningitis	<input type="checkbox"/> HIV	<input type="checkbox"/> Polio	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High fever	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> other lung illnesses	<input type="checkbox"/> other liver illnesses	<input type="checkbox"/> other heart illnesses	<input type="checkbox"/> other kidney illnesses
<input type="checkbox"/> other spleen illnesses	<input type="checkbox"/> other stomach illnesses	<input type="checkbox"/> other: _____	

Immunizations: \_\_\_\_\_

Surgeries and dates: \_\_\_\_\_

\_\_\_\_\_

### III. Family History

Family Member	Alive	Deceased	Present health or cause of death
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Child	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____

Where are you in the birth order?  first  last  middle  only

Check any of the following that have occurred in your blood relatives:

- Diabetes  Cancer  Heart disease  High blood pressure
- Allergies  Tuberculosis  Obesity  Bleeding tendency
- Kidney disease  Alcoholism  Nervous illness  Mental illness
- Stroke  Other \_\_\_\_\_  Other \_\_\_\_\_  Other \_\_\_\_\_

### IV. Patient profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

#### Is the pain:

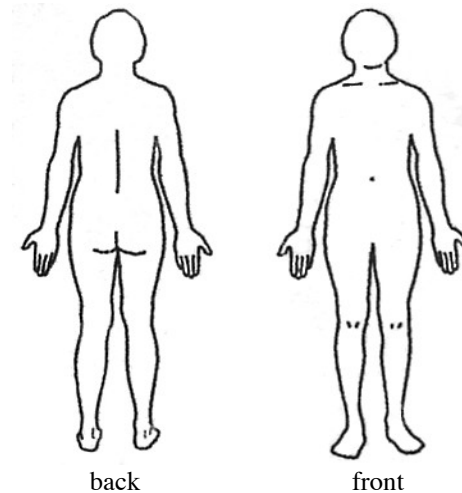
- Sharp  Burning  Aching
- Cramping  Dull  Moving
- Fixed  Other: \_\_\_\_\_

#### Do the following lessen the pain?

- Pressure  Cold  Heat
- Exercise  Other: \_\_\_\_\_

#### Do the following worsen the pain?

- Pressure  Cold  Heat
- Other: \_\_\_\_\_



Please check the following that currently (past 3 - 4 months) pertain to you:

**Overall Temperature (Kidney function):**

- Cold hands             Cold fingers             Cold feet             Cold toes
- Cold body temperature    Hot body temperature    Sweaty hands             Sweaty hands
- Sweaty feet             Afternoon flushes             Night sweats             Take water to bed
- Perspire easily             Lack of perspiration             Thirsty             Hot flashes any time of day
- Heat in the hands, feet, and chest

**Overall Energy (Lung, Kidney function):**

- Shortness of breath     General weakness             Easily catch colds             Low energy
- Difficulty keeping eyes open in the daytime             Feel worse after exercise

**Overall Blood (Liver, Spleen, Heart function):**

- Dizziness             See floating black spots

**Heart function:**

- Palpitations             Anxiety             Restlessness             Mental confusion
- Frequent dreams             Wake unrefreshed             Chest pain traveling to shoulder
- Sores on the tip of the tongue             Drink coffee/cola/caffeine (# cups per week: \_\_\_\_\_)

**Lung function:**

- Nasal Discharge (Color: \_\_\_\_\_)             Cough             Nose Bleeds
- Sinus Congestion             Dry throat             Dry Nose
- Alternating fever and chills             Sneezing             Stiff neck
- Overall achy feeling in the body             Sore throat             Difficulty breathing
- Smoke cigarettes (# cigarettes per day: \_\_\_\_\_)             Sadness             Melancholy
- Allergies (To what? \_\_\_\_\_)             Stiff Shoulders
- Headache (Location: \_\_\_\_\_)             Dry Skin

**Spleen function:**

- Low appetite             Abrupt weight gain             Abrupt weight loss             Abdominal bloating
- Abdominal gas             Fatigue after eating             Worry             Gurgling noise in stomach
- Easily bruised             Hemorrhoids             Pensive             Over thinking
- Prolapsed organs (previously diagnosed, organ) \_\_\_\_\_

**Spleen, Stomach, Large Intestine, Small Intestine function:**

- Loose             Constipated             Incomplete             Diarrhea
- Blood in stools             Mucous in stools             Undigested food in stools

**Dampness trapped in the body:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> General sensation of heaviness in the body | <input type="checkbox"/> Mental heaviness | <input type="checkbox"/> Mental sluggishness |   |
| <input type="checkbox"/> Mental fogginess                           | <input type="checkbox"/> Swollen hands    | <input type="checkbox"/> Swollen feet        | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Chest congestion                           | <input type="checkbox"/> Nausea           | <input type="checkbox"/> Snoring             |   |

**Stomach function:**

- |   |   |  |                                   |
|---|---|--|-----------------------------------|
| <input type="checkbox"/> Large appetite                 | <input type="checkbox"/> Bad breath         | <input type="checkbox"/> Stomach pain                      | <input type="checkbox"/> Hiccups  |
| <input type="checkbox"/> Canker sores                   | <input type="checkbox"/> Vomiting           | <input type="checkbox"/> Ulcer (diagnosed)                 | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Heartburn                      | <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Bleeding, swollen or painful gums |                                   |
| <input type="checkbox"/> Burning sensation after eating |   |  |                                   |

**Liver and Gall Bladder function:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Alternating diarrhea and constipation                                | <input type="checkbox"/> Chest pain                               | <input type="checkbox"/> Tight sensation in the chest     |   |
| <input type="checkbox"/> Bitter taste in the mouth  | <input type="checkbox"/> Anger easily                             | <input type="checkbox"/> Frustration                      |   |
| <input type="checkbox"/> Depression   | <input type="checkbox"/> Irritability                             | <input type="checkbox"/> Skin rashes                      | <input type="checkbox"/> Tingling sensation |
| <input type="checkbox"/> Frequently unable to adapt to stress (What causes the stress? _____) |   |   |   |
| <input type="checkbox"/> Headache at the top of the head                                      | <input type="checkbox"/> Numbness                                 | <input type="checkbox"/> Muscle spasms                    |   |
| <input type="checkbox"/> Muscle twitching   | <input type="checkbox"/> Muscle cramping                          | <input type="checkbox"/> Seizures                         | <input type="checkbox"/> Convulsions        |
| <input type="checkbox"/> Lump in the throat   | <input type="checkbox"/> Neck tension                             | <input type="checkbox"/> Limited range of motion, neck    |   |
| <input type="checkbox"/> Shoulder tension   | <input type="checkbox"/> Limited range of motion, shoulder        | <input type="checkbox"/> Gall stones (history or current) |   |
| <input type="checkbox"/> Recreational drugs (Which? _____ How much per week? _____)           |   |   |   |
| <input type="checkbox"/> High-pitched ringing in the ears                                     | <input type="checkbox"/> Drink alcohol (How much per week? _____) |   |   |
| <input type="checkbox"/> Sexually transmitted disease (Which? _____)                          |   |   |   |

**Eyes (Liver function):**

- |                                       |                                      |  |   |
|---------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Itchy        | <input type="checkbox"/> Bloodshot   | <input type="checkbox"/> Hot           | <input type="checkbox"/> Dry                    |
| <input type="checkbox"/> Watery       | <input type="checkbox"/> Gritty      | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Decreased night vision |
| <input type="checkbox"/> Near-sighted | <input type="checkbox"/> Far-sighted |  |   |

**Kidney, Urinary Bladder function:**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Frequent cavities                              | <input type="checkbox"/> Easily broken bones | <input type="checkbox"/> Sore knees            | <input type="checkbox"/> Weak knees                  |
| <input type="checkbox"/> Low back pain                                  | <input type="checkbox"/> Memory problems     | <input type="checkbox"/> Kidney stones         | <input type="checkbox"/> Cold sensation in the knees |
| <input type="checkbox"/> Excessive hair loss                            | <input type="checkbox"/> Fear                | <input type="checkbox"/> Easily startled       | <input type="checkbox"/> Lack of bladder control     |
| <input type="checkbox"/> Low-pitched ringing in the ears                | <input type="checkbox"/> Bladder infections  | <input type="checkbox"/> Early graying of hair |  |
| <input type="checkbox"/> Wake during the night twice or more to urinate |  |  |  |

**Libido/Sexual energy:**

- |                                 |                               |                              |
|---------------------------------|-------------------------------|------------------------------|
| <input type="checkbox"/> Normal | <input type="checkbox"/> High | <input type="checkbox"/> Low |
|---------------------------------|-------------------------------|------------------------------|

**Urination:**

- |                                       |                                      |                                    |                                      |
|---------------------------------------|--------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Normal color | <input type="checkbox"/> Dark yellow | <input type="checkbox"/> Clear     | <input type="checkbox"/> Reddish     |
| <input type="checkbox"/> Cloudy       | <input type="checkbox"/> Scanty      | <input type="checkbox"/> Profuse   | <input type="checkbox"/> Strong odor |
| <input type="checkbox"/> Burning      | <input type="checkbox"/> Painful     | <input type="checkbox"/> Discharge | <input type="checkbox"/> Difficult   |
| <input type="checkbox"/> Painful      | <input type="checkbox"/> Urgent      | <input type="checkbox"/> Frequent  | <input type="checkbox"/> Dribbling   |

**Women only:**

Pregnant?  Y  N    Number of pregnancies: \_\_\_\_\_    Number of children: \_\_\_\_\_

Regular menstrual cycle?  Y  N    Age of first menstruation: \_\_\_\_\_    Average number of days of flow: \_\_\_\_\_

Average number of days of entire cycle: \_\_\_\_\_     Vaginal discharge     Bleeding between periods

Age of menopause (if applicable): \_\_\_\_\_    Did/do you experience any symptoms during perimenopause (eg. hot flashes, insomnia, night sweats, depression, irritability, fatigue, etc)? If yes, describe: \_\_\_\_\_

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Do you experience any of the following **premenstrual** symptoms? Check all that apply.

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> nausea                  | <input type="checkbox"/> vomiting                 | <input type="checkbox"/> water retention | <input type="checkbox"/> breast swelling       |
| <input type="checkbox"/> food cravings           | <input type="checkbox"/> headaches                | <input type="checkbox"/> migraines       | <input type="checkbox"/> breast tenderness     |
| <input type="checkbox"/> depression              | <input type="checkbox"/> irritability             | <input type="checkbox"/> anxiety         | <input type="checkbox"/> other emotions: _____ |
| <input type="checkbox"/> dull pain, where? _____ | <input type="checkbox"/> sharp pain, where? _____ |  |  |

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other:							

**Men Only:**

- |  | Severe                   | Moderate                 | Slight                   | Normal                   |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Swollen testes  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Testicular pain                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Impotence   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Premature ejaculation                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Feeling of coldness or numbness in external genitalia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## DR PEA'S ACTIVE HEALTH CENTER

### PATIENT PRIVACY NOTICE - HIPPA RIGHTS

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. At Dr Pea's Active Health Center, we value our relationship with you and take your personal privacy seriously. This privacy notice explains how we manage the personal and health information we have obtained from you and how that information has been or may be collected. It also explains that your personal and health information is used in administering your health insurance. Please read this notice carefully.

#### INFORMATION WE COLLECT ABOUT YOU

We collect nonpublic personal information about you or your family when you contact us to make your initial appointment. This personal information may include your name, address, telephone number, email address, date of birth, Social Security number and your employer information. We ask that you complete a comprehensive health history form for your personal record, and we require verification of your health insurance for your specific plan coverage for you and all dependents.

#### HOW YOUR INFORMATION IS USED

The personal and health information we obtain and store is used to effectively administer your insurance benefits and to protect your health needs. Your personal health information may be discussed with your doctor or another health care provider. Your personal information may be requested by your insurance company to provide them information to properly file a claim. A laboratory may require some of your personal information, however, that is usually limited in nature. Your doctor may discuss aspects of your case with one of her colleagues or information may be given to a specialist in order to provide treatment. The information you have provided us may be used in the confirmation of appointments including messages left on answering machines, voice mail, or email.

#### SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We restrict access to your personal and health information to those employees who need to know that information to provide services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your personal and health information.

#### CHANGES TO OUR PRIVACY POLICY

Dr Pea's occasionally reviews its privacy policy and reserves the right to amend it. Should our privacy practices change, we will post a copy of the revised notice in our waiting area that indicates the date of the amended notice. You may request and obtain a copy of our Notice of Privacy Practices anytime you visit our office.

I have read and understand the above Privacy Notice for Dr Pea's Active Health Center

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_