

## Health and Lifestyle Questionnaire

All information you provide in this questionnaire will be treated as private and confidential. It will only be released to other individuals with your written permission.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Occupation / Employer \_\_\_\_\_ Church / Religion \_\_\_\_\_

Marital Status:  single  married  divorced  widowed

Spouse's name \_\_\_\_\_ Ages of children \_\_\_\_\_

What is the best time and method to get in touch with you? \_\_\_\_\_

What is your height \_\_\_\_\_ Weight \_\_\_\_\_ Desired weight \_\_\_\_\_

**Please list your main health concerns or issues:**

- 1.
- 2.
- 3.
- 4.

What active medical conditions are you currently receiving treatment for:

Condition	Date started	Current Treatment
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1.

2.

3.

4.

5.

6.

Please list all drug allergies: (specify if "none")

Please list any non-drug allergies you experience such as food allergies, environmental, animals, etc:

Specify all medications you are currently using: (include hormones and non-prescription medicines)

Name \_\_\_\_\_ Dose \_\_\_\_\_ Times/Day \_\_\_\_\_

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Name \_\_\_\_\_ Dose \_\_\_\_\_ Times/Day \_\_\_\_\_

Name \_\_\_\_\_ Dose \_\_\_\_\_ Times/Day \_\_\_\_\_

List all surgical procedures you have had (with dates) – include cosmetic surgery:

Are you currently receiving other alternative or “natural” therapies:

- |                                       |                                      |   |
|---------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> chiropractic | <input type="checkbox"/> acupuncture | <input type="checkbox"/> therapeutic massage    |
| <input type="checkbox"/> homeopathy   | <input type="checkbox"/> colonics    | <input type="checkbox"/> chelation              |
| <input type="checkbox"/> kinesiology  | <input type="checkbox"/> juicing     | <input type="checkbox"/> herbal (specify _____) |
| <input type="checkbox"/> other _____  |                                      |   |

Do you or your close family members have a history of:

	<u>Myself</u>	<u>Family Member (specify who)</u>
Cancer	<input type="checkbox"/>	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/> _____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> _____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/> _____
Lung disease	<input type="checkbox"/>	<input type="checkbox"/> _____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/> _____
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/> _____
Liver disease	<input type="checkbox"/>	<input type="checkbox"/> _____
Bowel disease	<input type="checkbox"/>	<input type="checkbox"/> _____
Psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/> _____
Alcohol / drug addiction	<input type="checkbox"/>	<input type="checkbox"/> _____
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/> _____

Have you been exposed to potentially harmful chemicals, metals, or radiation at home or at work? (for example – dental fillings, pesticides, radioactivity, solvents)

Exposed to: \_\_\_\_\_ When Exposed: \_\_\_\_\_ How Exposed: \_\_\_\_\_

Smokers: Type smoked \_\_\_\_\_ Amount per day \_\_\_\_\_ Age started \_\_\_\_ Age stopped \_\_\_\_

Alcohol consumption: Drinks/week \_\_\_\_\_ Typical beverages \_\_\_\_\_

Coffee: Cups/day \_\_\_\_\_ Diet Soda or other drinks with Aspartame/day \_\_\_\_\_

Recreational Drug Use \_\_\_\_\_

Exercise Summary: Are you currently involved in an exercise program?  Yes  No

Describe your current exercise \_\_\_\_\_

Describe and limitations or problems you have with activity or exercise \_\_\_\_\_

Do you have exercise equipment at home?  Yes  No

Are you an active member of a health club or gym?  Yes  No

Are you presently receiving physical therapy?  Yes  No

If yes, describe:

What sort of exercise program would you prefer to do if there were no limitations? (describe)

Sleep History:

- Number of hours you typically sleep each night \_\_\_\_\_
- Do you usually sleep well and awaken refreshed?  Yes  No
- Do you have trouble falling asleep?  Yes  No
- Do you often wake during the night and have trouble falling asleep again?  Yes  No
- Do you have a history of snoring or sleep apnea?  Yes  No
- Do you get sleepy or take naps during the day?  Yes  No
- Do you use sleeping medication or other aids to help fall asleep?  Yes  No

Nutrition Summary:

Describe any specific philosophy or approach you have to nutrition and diet:

What special diets have you tried in the past? What results?

What foods do you consistently overeat?

- Do you crave
- sugar and sweets  Yes  No
  - breads and pasta  Yes  No
  - chocolate  Yes  No
  - salty foods  Yes  No
  - fatty foods  Yes  No
  - other \_\_\_\_\_

Describe your nutrition on a typical "good day" (please list a typical menu of food you eat)

Breakfast (time \_\_\_\_\_)

Morning snack (time \_\_\_\_\_)

Lunch (time \_\_\_\_\_)

Afternoon snack (time \_\_\_\_\_)

Supper (time \_\_\_\_\_)

Evening snack (time \_\_\_\_\_)

Describe your nutrition on a typical "bad day"

Breakfast (time \_\_\_\_\_)

Morning snack (time \_\_\_\_\_)

Lunch (time \_\_\_\_\_)

Afternoon snack (time \_\_\_\_\_)

Supper (time \_\_\_\_\_)

Evening snack (time \_\_\_\_\_)

Please list any vitamins, herbals, or other supplements you currently take: (use additional page if necessary)

On a scale of 1 to 10, please rate the following areas in your life at the present time:

	Worst		Poor		OK		Pretty Good		Best	
My energy level is:	1	2	3	4	5	6	7	8	9	10
My appetite is:	1	2	3	4	5	6	7	8	9	10
My diet is:	1	2	3	4	5	6	7	8	9	10
My sleep is:	1	2	3	4	5	6	7	8	9	10
My exercise is:	1	2	3	4	5	6	7	8	9	10
My symptoms are:	1	2	3	4	5	6	7	8	9	10
My attitude is:	1	2	3	4	5	6	7	8	9	10
My overall health is:	1	2	3	4	5	6	7	8	9	10

Females Only:

Date of Last Menstrual period: \_\_\_\_\_

Date of last: Breast exam \_\_\_\_\_ PAP smear \_\_\_\_\_ Mammogram \_\_\_\_\_

Do you have issues or concerns with:

Describe: \_\_\_\_\_

- Hormone balance  Yes  No
- Missed or irregular periods  Yes  No
- Hot flashes  Yes  No
- Premenstrual symptoms  Yes  No
- Infertility  Yes  No

Males and Females:

When was the approximate date that you most recently had the following:

- Complete physical exam \_\_\_\_\_
- Diagnostic blood tests \_\_\_\_\_
- Dental check-up \_\_\_\_\_
- Vision exam \_\_\_\_\_
- Hearing test \_\_\_\_\_
- EKG \_\_\_\_\_
- Exercise stress test (treadmill or other) \_\_\_\_\_
- Sigmoidoscopy or Colonoscopy \_\_\_\_\_
- Stool exam for blood \_\_\_\_\_
- Lung function tests \_\_\_\_\_
- Bone density scan \_\_\_\_\_

Were any of the above tests abnormal? Please describe:

Who is your primary health care provider? \_\_\_\_\_ Specialty? \_\_\_\_\_

Their office phone number: \_\_\_\_\_ Do you give permission for Dr. Billica to discuss your medical situation with your primary health care provider? Yes \_\_\_\_\_ No \_\_\_\_\_

Your signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL SYMPTOMS QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

*Rate each of the following symptoms based on your typical health profile for the past 30 days.*

Point scale: 0 = never or almost never have the symptom  
1 = occasionally have it, effect is not severe  
2 = occasionally have it, effect is severe  
3 = frequently have it, effect is not severe  
4 = frequently have it, effect is severe

HEAD \_\_\_\_\_ Headaches  
\_\_\_\_\_ Faintness  
\_\_\_\_\_ Dizziness  
\_\_\_\_\_ Insomnia  
Total \_\_\_\_\_

EYES \_\_\_\_\_ Watery or itchy eyes  
\_\_\_\_\_ Swollen, reddened, or sticky eyelids  
\_\_\_\_\_ Bags or dark circles under eyes  
\_\_\_\_\_ Blurred or tunnel vision  
(does not include near- or far-sightedness)  
Total \_\_\_\_\_

EARS \_\_\_\_\_ Itchy ears  
\_\_\_\_\_ Earaches, Ear infections  
\_\_\_\_\_ Drainage from ear  
\_\_\_\_\_ Ringing in ears, hearing loss  
Total \_\_\_\_\_

NOSE \_\_\_\_\_ Stuffy nose  
\_\_\_\_\_ Sinus problems  
\_\_\_\_\_ Hay fever  
\_\_\_\_\_ Sneezing attacks  
\_\_\_\_\_ Excessive mucous formation  
Total \_\_\_\_\_

MOUTH / THROAT \_\_\_\_\_ Chronic coughing  
\_\_\_\_\_ Gagging, frequent need to clear throat  
\_\_\_\_\_ Sore throat, hoarseness, loss of voice  
\_\_\_\_\_ Swollen or discolored tongue, gum, lips  
\_\_\_\_\_ Canker or cold sores  
Total \_\_\_\_\_

SKIN \_\_\_\_\_ Acne  
\_\_\_\_\_ Hives, rashes  
\_\_\_\_\_ Dry skin  
\_\_\_\_\_ Hair loss  
\_\_\_\_\_ Flushing, hot flashes  
\_\_\_\_\_ Excessive sweating  
Total \_\_\_\_\_

HEART \_\_\_\_\_ Irregular or skipped heartbeat  
\_\_\_\_\_ Rapid or pounding heartbeat  
\_\_\_\_\_ Chest pain or pressure  
Total \_\_\_\_\_

LUNGS \_\_\_\_\_ Chest congestion  
\_\_\_\_\_ Asthma, wheezing, bronchitis  
\_\_\_\_\_ Shortness of breath  
\_\_\_\_\_ Difficulty breathing  
Total \_\_\_\_\_

DIGESTIVE TRACT	<input type="checkbox"/>	Nausea, vomiting	
	<input type="checkbox"/>	Diarrhea	
	<input type="checkbox"/>	Constipation	
	<input type="checkbox"/>	Bloated feeling	
	<input type="checkbox"/>	Belching, passing gas	
	<input type="checkbox"/>	Heartburn, indigestion	
	<input type="checkbox"/>	Intestinal, stomach pain	Total <input type="text"/>
JOINTS / MUSCLES	<input type="checkbox"/>	Pain or aches in joints	
	<input type="checkbox"/>	Arthritis	
	<input type="checkbox"/>	Stiffness or limitation of movement	
	<input type="checkbox"/>	Pain or aches in muscles	
	<input type="checkbox"/>	Feeling of muscle weakness	Total <input type="text"/>
GENITOURINARY	<input type="checkbox"/>	Frequent or urgent urination	
	<input type="checkbox"/>	Having to get out of bed to urinate at night	
	<input type="checkbox"/>	Difficulty starting or stopping urine stream	
	<input type="checkbox"/>	Urinary incontinence	
	<input type="checkbox"/>	Genital itch, discharge, or sores	
	<input type="checkbox"/>	Vaginal yeast infections (women)	Total <input type="text"/>
WEIGHT	<input type="checkbox"/>	Binge eating / drinking	
	<input type="checkbox"/>	Craving certain foods	
	<input type="checkbox"/>	Excessive weight, inability to lose weight	
	<input type="checkbox"/>	Compulsive eating	
	<input type="checkbox"/>	Water retention	
	<input type="checkbox"/>	Underweight, inability to gain weight	Total <input type="text"/>
ENERGY / ACTIVITY	<input type="checkbox"/>	Fatigue, sluggishness	
	<input type="checkbox"/>	Apathy, lethargy	
	<input type="checkbox"/>	Hyperactivity	
	<input type="checkbox"/>	Restlessness	Total <input type="text"/>
MIND	<input type="checkbox"/>	Poor memory	
	<input type="checkbox"/>	Confusion, poor comprehension	
	<input type="checkbox"/>	Poor concentration	
	<input type="checkbox"/>	Poor physical coordination	
	<input type="checkbox"/>	Difficulty in making decisions	
	<input type="checkbox"/>	Stuttering or stammering	
	<input type="checkbox"/>	Slurred speech	
	<input type="checkbox"/>	Learning disabilities	Total <input type="text"/>
EMOTIONS	<input type="checkbox"/>	Mood swings	
	<input type="checkbox"/>	Anxiety, fear, nervousness	
	<input type="checkbox"/>	Anger, irritability, aggressiveness	
	<input type="checkbox"/>	Depression	
	<input type="checkbox"/>	Lack of sex drive, decreased libido	
	<input type="checkbox"/>	Suicidal thinking or behavior	Total <input type="text"/>
OTHER	<input type="checkbox"/>	Frequent illness, slow recovery from illness	
	<input type="checkbox"/>	Fever, chills, or night sweats	
	<input type="checkbox"/>	Cold hands or feet	
	<input type="checkbox"/>	Burning, numbness, tingling in hands or feet	
	<input type="checkbox"/>	Excessive thirst	
	<input type="checkbox"/>	Sleep problems, insomnia	
	<input type="checkbox"/>	Food intolerances, food allergies	Total <input type="text"/>

OVERALL TOTAL \_\_\_\_\_