



a center for healing and healthy beginnings

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HEALTH HISTORY QUESTIONNAIRE

Please complete the following life history questionnaire to the best of your ability. You may need family members to help supply information. Your thoroughness and accuracy in answering all appropriate questions will help the doctor evaluate the root cause of your health concerns and determine an effective treatment program. Note that, besides major problems, he is interested in so-called minor symptoms. These include any odd or unusual message you are getting from your body, even though it may be considered irrelevant to making a diagnosis or it may seem to you to be of no consequence to your health. Some such symptoms are useful clues in the kind of "medical detective work" that is being done. Please include as much information as you can on this form.

Please print or write legibly.

Name Date

Address

City State Zip Code

Home Phone Work Phone

E-mail Social Security Number

Age Date of Birth Place of Birth

Gender [] female [] male

[] Married [] Separated [] Divorced [] Widowed [] Single [] Partnership

Occupation Hours per week [] Retired

Employer

Work Address

City State Zip Code

How did you hear about our clinic?

Has any other family member already been a patient at the clinic?

Next of kin or other to reach in an emergency

Relationship Phone

Address

City State Zip Code

PRESENT HEALTH CONCERNS

Please list your most important health concerns/symptoms (chief complaint) and the approximate date it began (if none, please write your reason for seeking this consultation). If possible, please list them in order of importance to you. For example, #1 is most important, and #7 is least important.

Table with 4 columns: PROBLEM, ONSET, FREQUENCY, SEVERITY. Row 1: Eg. Headaches, June 2007, 4 times per week, Mild/moderate/severe.

What diagnosis or explanation has been given to you? _____

Who is your primary medical physician? _____

Primary medical physician address and office phone: _____

Please list all of the alternative treatments you have tried for your condition(s)? _____

Medical procedures, hospitalizations, major injuries, and serious illnesses: Please list previous medical procedures, surgeries, hospitalizations, and serious illnesses.

APPROXIMATE DATE/YEAR	SURGERY / HOSPITALIZATIONS / PROCEDURES / SERIOUS ILLNESSES / INJURIES

DIAGNOSTIC STUDIES	DATE	DATE	DATE	COMMENTS / RESULTS
Chest X-Ray				
Mammogram				
EKG				
Sigmoidoscopy				
Colonoscopy				
Upper GI Series				
Barium Enema				
CAT Scan of Brain				
CAT Scan of Spine				
Liver Scan				
Bone Scan				
Blood Density Test				
Other				
OPERATIONS				
Tonsillectomy				
Tubes in Ears				
Appendectomy				
Gall Bladder				
Hernia				
Hysterectomy				
Other				

Current prescription medications (e.g. Prozac, atenolol, etc.), non-prescription medications (e.g., aspirin, Tylenol, ibuprofen) and/or health supplements (e.g., vitamins, minerals, herbs): Please list the medications and/or supplements that you are currently taking with dosages (use separate sheet if needed):

NAME of Medication / supplement – drugs, vitamins, herbs, minerals	DOSE in milligrams or grams or number of capsules / tablets	FREQUENCY Times per day/week/month	For what condition are you taking these?

FAMILY HISTORY

Please mark any health problem(s) your family has suffered with either currently or in the past.

PRESENT AGE	PATERNAL				MATERNAL	
	FATHER	MOTHER	GRANDMOTHER	GRANDFATHER	GRANDMOTHER	GRANDFATHER
If deceased, age?						
Heart attack						
Stroke						
Uterine Cancer						
Emphysema						
Arthritis						
RAS						
Lupus						
Diabetes						
Parkinson's						
Alzheimer's						
Osteoporosis						
Glaucoma						
Colon Cancer						
Breast Cancer						
Prostate Cancer						
High Blood Pressure						
Skin Cancer						
Depression						
MS						
Alcohol Addiction						
Smoking Addiction						
Asthma						
Pneumonia/Bronchitis						
Obesity						
Flu						
Headache						
Insomnia						
High Cholesterol						
Other						

REVIEW OF SYSTEMS

Check only those items with which you identify, past or present. Ignore anything that does not apply to you.

GENERAL

- Fever
- Chills/Cold all over
- Aches/Pains
- General Weakness
- Difficulty sweating
- Excessive Sweating
- Swollen Glands
- Cold hands & Feet
- Fatigue
- Difficulty falling asleep
- Night Walker
- Nightmares
- No dream recall
- Early waking
- Daytime sleepiness
- Distorted Vision

SKIN

- Cuts Heal slowly
- Bruise Easily
- Rash
- Pigmentation
- Changing Moles
- Calluses
- Eczema
- Psoriasis
- Dryness
- Oiliness
- Itching
- Acne
- Boils
- Hives
- Fungus on Nails
- Peeling Skin
- Cracking skin
- Shingles
- Nails Split
- White Spots/Lines on Nails
- Crawling Sensation
- Burning on Bottom of Feet
- Athletes Foot
- Cellulite
- Bugs love to bite you
- Bumps on the back of arms / front of thighs
- Skin Cancer
- Strong body odor

Is your skin sensitive to the:

- Sun
- Fabrics _____
- Detergents _____

HEAD

- Poor Concentration
- Confusion
- Headaches:
- After Meals
- Severe
- Migraine
- Frontal
- Afternoon
- Occipital
- Afternoon
- Daytime
- Relieved by:
- Eating Sweets
- Concussion/Whiplash
- Mental Sluggishness
- Forgetfulness
- Indecisive
- Face Twitch
- Poor Memory
- Hair Loss

EYES

- Sand in Eyes
- Double Vision
- Blurred Vision
- Poor Night Vision
- Bright Flashes
- Halo around Lights
- Eye Pains
- Dark Circles under Eyes
- Strong Light Irritates
- Cataracts
- Floaters in Eyes
- Visual hallucinations

EARS

- Aches
- Discharge/Conjunctivitis
- Pains
- Ringing
- Deafness/Hearing loss
- Itching
- Pressure
- Wear a hearing aid
- Frequent infections
- Tubes in ears
- Sensitive to loud noises
- Hearing Hallucinations

NOSE/SINUSES

- Stuffy
- Bleeding
- Running
- Discharge
- Watery Nose

- Congested
- Infection
- Polyps
- Acute smell
- Drainage
- Sneezing spells
- Post nasal drip
- No sense of smell
- Do the change of seasons tend to make your symptoms worse? Yes No
- If yes, is it worse in the:
 - Spring
 - Summer
 - Fall
 - Winter

MOUTH

- Coated Tongue
- Sore Tongue
- Teeth Problems
- Bleeding Gums
- Canker Sores
- TMJ
- Cracked lips/ corners
- Chapped lips
- Fever blisters
- Wear dentures
- Grind teeth when sleeping
- Bad breath
- Dry mouth

THROAT

- Mucus
- Difficulty Swallowing
- Frequent Hoarseness
- Tonsillitis
- Enlarged Glands
- Constant clearing of throat
- Throat closes up

NECK

- Stiffness
- Swelling
- Lumps
- Neck glands swell

CIRCULATION/RESPIRATION

- Swollen Ankles
- Sensitive to Hot
- Sensitive to Cold
- Extremities Cold or Clammy
- Hands/Feet go to sleep/numb
- High Blood Pressure
- Chest Pain
- Pain between shoulders
- Dizziness upon standing

- Fainting Spells
- High Cholesterol
- High Triglycerides
- Wheezing
- Irregular Heartbeat
- Palpitations
- Low exercise tolerance
- Frequent coughs
- Breathing heavily
- Frequently Sighing
- Shortness of breath
- Night Sweats
- Varicose Veins
- Mitral valve prolapse
- Murmurs
- Skipped heartbeat
- Heart enlargement
- Angina pain
- Bronchitis/Pneumonia
- Emphysema
- Croup
- Frequent colds
- Heavy/tight chest
- Past Heart Attack? When _____
- Phlebitis
- Spider Veins

GASTROINTESTINAL/DIGESTION

- Peptic/Duodenal Ulcer
- Poor Appetite
- Excessive Appetite
- Gallstones
- Gallbladder pain
- Nervous Stomach
- Full Feeling after meal
- Indigestion
- Heartburn
- Acid Reflux
- Hiatal Hernia
- Nausea
- Vomiting
- Vomiting Blood
- Abdominal Pains/Cramps
- Gas
- Diarrhea
- Constipation
- Changes in Bowels
- Rectal Bleeding
- Tarry Stools
- Rectal Itching
- Use laxatives
- Bloating
- Belch frequently
- Anal itching
- Anal fissures
- Bloody stools
- Undigested food in stools

KIDNEY/URINARY TRACT

- Burning
- Frequent Urination
- Blood in Urine
- Night time Urination
- Problem Passing Urine
- Kidney Pain
- Kidney Stones
- Painful Urination
- Bladder infections
- Kidney infections
- Syphilis
- Bedwetting
- Have trichomonas

MALE REPRODUCTIVE SYSTEM

- Lumps in testicles
- Sore on penis
- Erection Problems
- Impotence
- Diminished Sex drive
- Hernia
- Enlarged Prostate
- Prostate Cancer
- Low Sperm Count
- Infertility
- Poor Libido
- Genital Pain

FEMALE REPRODUCTIVE SYSTEM

- Fibroid Tumors/Breast
- Fibroid Tumors/Uterus
- Lumps in Breast
- Breast soreness before period
- Breast soreness during period
- Breast Cancer
- Ovarian Cysts
- Vaginal Discharge
- Non-Period Bleeding
- Spotting
- Hot flashes
- Diminished sex drive
- Change in period
- Endometriosis
- Pregnant
- Infertility
- Had partial/total hysterectomy
- Had breast biopsy
- Had miscarriage
- Use contraceptive pill
- Age you began menses? _____
- Age at menopause? _____
- Number of children _____
- C-section
- Are you taking hormone replacement therapy?
If yes, what medication? _____
- Estrogen

- Estrace
- Premarin
- Ogen
- Progesterone
- Provera
- Other _____

Date of last PAP SMEAR? _____

JOINT/MUSCLES/TENDONS

- Pain wakes me up
- Weakness in Legs and arms
- Balance problems
- Muscle cramping
- Head injury
- Muscle Stiffness in Morning
- Damp weather bothers you

AGE

Please list the age(s) you had or suffered from the following:

- ___ Frequent colds or flu
- ___ Tonsillitis
- ___ Bronchitis
- ___ Ear Infections
- ___ Measles
- ___ Mumps
- ___ Chicken Pox
- ___ Whooping Cough
- ___ Frequent Antibiotics
- ___ Strep Infections
- ___ Seasonal allergies
- ___ Significant dental work
- ___ Behavior problems
- ___ ADD
- ___ Hyperactivity
- ___ Difficulty learning:
- ___ Frequent headaches
- ___ High # of absences from school
- ___ Upset stomach, indigestion
- ___ Jaundice
- ___ Colic
- ___ Ear infections
- ___ Congenital abnormalities
- ___ Premature at birth
- ___ Pneumonia
- ___ Fever blisters
- ___ Parent (s) smoked
- ___ Abusive or alcoholic parent (s)
- ___ Skin disorders (eczema)
- ___ Major illness(s) that required hospitalization

Please explain your illness: _____

IMMUNIZATIONS:

Have you ever had:

- Smallpox vaccination?
- DDT or Tetanus toxoid?
- Polio immunization?
- Mumps immunizations?
- Measles immunizations?

EMOTIONAL

- Convulsions
- Dizziness
- Fainting Spells
- Blackouts
- Amnesia
- Had shock therapy
- Frequently keyed up and jittery
- Shaky
- Startled by sudden noises
- Often feel suddenly scared
- Go to pieces easily
- Forgetful
- Listless
- Withdrawn feeling
- Feel "lost" in time
- Had nervous breakdown
- Had "burnout"
- Feel groggy
- Unable to concentrate
- Short attention span
- Vision changes
- Unable to reason
- Considered a nervous person
- Worried over little things
- Anxiety
- Unusual tension
- Frustration
- Numbness
- Often break out in cold sweats
- Profuse sweating
- Depressed
- Been admitted for psychiatric care
- Often awakened by frightening dreams
- Family member had nervous breakdown
- Use tranquilizers
- Aggressive
- Misunderstood by others
- Irritable
- Easily flare in anger
- Feeling of hostility
- Fatigue
- Hyperactive
- Restless leg syndrome
- Considered clumsy
- Unable to coordinate muscles
- Have difficulty falling asleep
- Have difficulty staying asleep
- Daytime sleepiness

- Am a workaholic
- Have had hallucinations
- Have considered suicide
- Have overused alcohol
- Family history of overused alcohol
- Cry often
- Feel insecure
- Have overused drugs
- Been addicted to drugs
- Extremely shy

IS YOUR LIFE

- Satisfactory
- Boring
- Demanding
- Unsatisfactory

DO YOU WORRY OVER?

- Home life
- Marriage
- Children
- Job
- Income
- Money Problems

TOXIC STRESS TRIGGERS

(These refer to on-going stress that has accumulated over months or years. Please mark any of the above that you have experienced in your lifetime)

- Childhood traumas
- Perfectionism
- Divorce or change in a relationship
- Caregiving: taking care of a sick family member
- Job or career challenges
- Illness, either short-term or chronic
- Dieting: constantly trying a new and improved diet program
- Menopause

THANK YOU!

Thank you for taking the time to complete this health history medical questionnaire. If you have not completed the other questionnaires that were given to you then please do so now. The information derived from all of these medical forms will provide invaluable data.

Each section builds upon the other, allowing me the opportunity to discover the "missing key" that will solve your health problem. Once all of the forms and questionnaires have been filled out please return them to our office and we'll make an appointment for our initial consultation. I thank you once again and look forward to helping you achieve a "return to health and well being."

Sincerely,
Dr. Zachary Watkins