Evolution Healthcare and Fitness | 905 SE Ankeny St, Portland, OR 97214 | 971.236.7610 | F: 503.954.1504

Confidential Health History Questionnaire

Danielle Melanson, LAc

Name: ____________________________________ Date: ______________________ DOB:_________
Address: ____
Email: _________________________________ Phone ____
What are the concerns for which you are seeking care? (Primary concern first)

1. ____ Date of Onset: ____________________
2. ____ Date of Onset: ____________________
3. ____ Date of Onset: ____________________

Are you seeking primary care from Evolution Healthcare and Fitness? ☐ Yes ☐ No
If No, who is your primary care physician? ____
For what concern did you last receive health or medical care? ____________________________
____

Medications and Supplements:

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking? ____
____
Check each that you currently use:

- Laxatives
- Antibiotics
- Sleeping Pills
- Pain Relievers
- Allergy Medication
- Heart/Blood Medication
- Anti-Depressants
- Antacids
- Birth Control Pills
- Cortisone
- Thyroid Medication
- Hormones

Do you have any known contagious diseases at this time? ☐ No ☐ Yes If yes, what? ______________
Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters, or children. Indicate the number of relatives who have the disease.

- Cancer
- Heart Disease
- Anemia
- Allergies
- Arthritis
- Diabetes
- High Blood Pressure
- Kidney Disease
- Asthma
- Tuberculosis
- Epilepsy
- Stroke
- Glaucoma
- Mental Illness
- Alzheimer's

Other Conditions: ____

Have you had any of the following Childhood Illness (check if yes)

- Scarlet Fever
- Diphtheria
- Rheumatic Fever
- Mumps
- Measles
- German Measles

Have you had negative reactions to immunizations? ☐ No ☐ Yes_ if yes, what? ___________________

Hospitalizations, Surgery, X-Ray and Special Studies

What hospitalizations, surgeries, x-rays, or special studies have you had?
____ Year __________
____ Year __________
____ Year __________
____ Year __________

Allergies

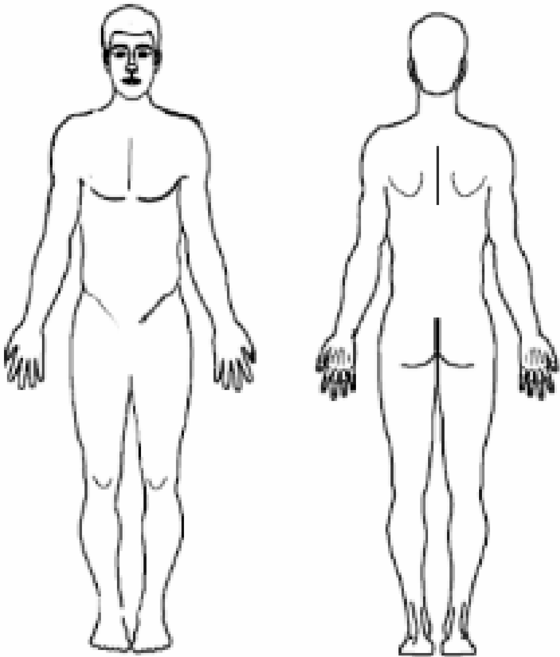
Are you hypersensitive or allergic to any foods, drugs, or environmental substances? Please list:
____

General

Blood Type _________ Current Weight ________lbs Maximum weight _____lbs
Height ________inches Weight 1 year ago ______lbs When was this? _________

Review of Symptoms

Please shade in areas where you are experiencing pain on figures (if applicable).



Lifestyle Habits (Check all applicable)

Main interests and hobbies? ________________

- o Exercise, what kind? ________________
  How often do you exercise? __________
- o Average of 6-8 hrs. of sleep
- o Have a supportive relationship
- o History of abuse
- o Major traumas
- o Use recreational drugs
- o Treated for drug dependence
- o Drink coffee
- o Drink black or green tea
- o Drink cola or other sodas
- o Add salt to your food
- o Eat refined sugar
- o Enjoy your work
- o Take vacations
- o Spend time outside
- o Watch TV? How much? _____________
- o Read? How often? _________________
- o Use alcoholic beverages? # per week ___
- o Treated for alcoholism
- o Use tobacco currently
- o Used tobacco in the past? How long? ___
  How many packs per day? _____
- o Have a religious/spiritual practice

Check any of the following you have or have had in the past 6 months

SKIN
- o Rashes
- o Eczema, Hives
- o Acne, Boils
- o Itching
- o Fungal Infections
- o Color change
- o Hair loss
- o Dry skin / scalp
- o Lumps
- o Night sweats
- o Slow healing ulcerations
- o Flushing or hot flashes

NOSE AND SINUSES
- o Frequent colds
- o Nose bleeds
- o Stuffiness
- o Hay fever
- o Sinus problems
- o Loss of smell

HEAD / NECK
- o Headache/migraine
- o Faintness
- o Dizziness
- o Jaw pain
- o Swollen glands
- o Goiter
- o Pain or stiffness

RESPIRATORY
- o Chest congestion
- o Wheezing
- o Asthmas
- o Difficulty/pain breathing
- o Shortness of breath
- o Cough ___wet or ___dry
- o Coughing blood

IMMUNE
- o Chronic fatigue syndrome
- o Chronic infections
- o Chronically swollen glands
- o Slow wound healing

MUSCLES / JOINTS / BONES
- o Joint pain
- o Muscle pain
- o Muscle spasms / cramps
- o Restless leg syndrome
- o Sciatica

NEUROLOGIC
- o Seizures
- o Paralysis
- o Muscle weakness
- o Numbness or tingling
- o Easily stressed
- o Vertigo or dizziness
- o Loss of balance

MOUTH AND THROAT
- o Sore throat
- o Copious saliva
- o Teeth grinding
- o Sore tongue / lips
- o Gum problems
- o Hoarseness

EYES AND EARS
- Itchy eyes
- Watery eyes
- Dry eyes
- Swollen / painful eyes
- Red eyes
- Impaired vision / blurriness
- Floaters in vision
- Cataracts
- Color blindness
- Double vision
- Glaucoma
- Hearing difficulty
- Ringing
- Earaches / infection

Cardiovascular
- Heart disease
- Angina/ chest pain
- High / low blood pressure
- Murmurs
- Blood clots
- Irregular heart beat
- Palpitations / fluttering
- Swelling in ankles

Circulation
- Easy bleeding or bruising
- Anemia
- Deep leg pain
- Varicose veins
- Cold hands / feet

Endocrine
- Hypothyroid
- Heat or cold intolerance
- Hypoglycemia
- Diabetes
- Excessive thirst
- Excessive hunger
- Seasonal depression

Digestion
- Trouble swallowing
- Heartburn / acid reflux
- Change in thirst / appetite
- Ulcer
- Nausea / vomiting
- Gas / bloating
- Belching or passing gas
- Diarrhea
- Constipation
- Pain or cramps
- Mucous in stool
- Black / bloody stool
- Hemorrhoids
- Itchy / burning anus
- Rectal pain
- Jaundice (yellow skin)

Bowel movements: How often? _______________

Is this a change? _______

Stools: ☐ Hard ☐ Firm ☐ Soft ☐ Loose

Urinary
- Pain on urination
- Increased frequency
- Frequency at night
- Frequent infections
- Inability to hold urine
- Kidney stones
- Blood in urine

Mental / emotional
- Mood swings
- Anxiety or nervousness
- Considered / attempted suicide
- Depression
- Poor concentration
- Poor memory

Other: ________________

General
- Poor sleep / insomnia
- Fatigue / low energy
- Chills or fevers
- Cravings ___________
- Peculiar taste in mouth
- Low libido
- Experience high stress

Reproductive

Are you sexually active?
☐yes ☐no

Sexual orientation: __________

Birth control type: ___________

- Irregular cycles
- Bleeding between cycles
- Pain during intercourse
- Clotting
- Heavy or excessive flow
- PMS
- Endometriosis
- Difficulty conceiving
- Painful menses
- Vaginal discharge? Color?
- Vaginal odor
- Ovarian cysts
- Menopausal symptoms
- Abnormal PAP
- Sexually transmitted disease
- Breast pain / tenderness
- Nipple discharge
- Breast lumps

Age at which menses began ___

Age of last menses (if menopausal) _______________

Cycle length (Day 1 to Day 1) _

Duration of flow ____________

Date of last period ___________

Birth control? Type: _________

Number of pregnancies _______

Number of live births ________

Number of miscarriages ______

Number of abortions _________

- Difficult or premature births

Do you do breast self-exams?
☐yes ☐ no

Date of last Pap smear _____

Date of last mammogram ___

Could be pregnant now? ___

- Hernias
- Testicular masses
- Testicular pain
- Prostate disease
- Sexually transmitted disease
- Discharge or sores
- Sexual dysfunction

Context of our Overview

We would like to take this moment to welcome you to our practice. Whether you were referred by another practitioner for a one-time visit, or are looking for a longer-term comprehensive health solution, we look forward to our role in your care. Below are a few questions that really assist us in understanding “where you’re coming from” and how we can best support your health.

1. How did you discover our clinic and how did you decide to see us now?

2. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

3. What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

4. What do you love most about your life at this time?

5. What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructing lifestyle habits? (Please list)

6. What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

7. What are your top three expectations of us?