***Purity Integrative Health & Wellness Center, PLLC***

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| HEALTH HISTORY QUESTIONNAIRE | | | | | | | | | | | | | | | | | | | | |
| All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Date & Time of Initial Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | |
| Name  Full Legal Name: |  | | | | | | | | | | | | | | | | | | | |
| Date of Birth: | | | | | | | | | | | | | | | | | | | | |
| Gender Identification: 🞎 M 🞎 F 🞎 Other: | | | | | | | | | | | | | | | | | | | | |
| Social Security Number: | | | | | | |  | | | | | | | | | | | | | |
| Address: | | | | |  | | | | | | | | | | | | | | | |
| CITY: | | | | |  | | | | | | | **STATE:** | | | | **ZIP:** | | | | |
| **Mailing Address if different from above:** | | | | | | | | | | | | | | | | | | | | |
| Email address: | | | | |  | | | | | | | | | | | \*\*Required | | | | |
| **Home Phone:** | | | | | | | | | | | **Cell Phone:** | | | | | | | | | |
| **Preferred method of contact: home phone / cell phone / other:** | | | | | | | | | | | | | | | | | | | | |
| Marital status: | | | | | 🞎 Single 🞎 Partnered 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed | | | | | | | | | | | | | | | |
| Primary Care doctor: | | | | | |  | | | | | | | | **Date of last physical exam:** | | | | | | |
| **Clinic your PCP is associated with:** | | | | | | | | | | | | | | | | | | | | |
| **How did you hear about us:**  Referred by someone specific? :  Internet Search: Google/Bing / Insurance Website / Phone book / Newspaper Ad / Brochure in community / Website [www.purityhealth.net](http://www.purityhealth.net) / AANP Website/ WANP Website / Saw Signs or Drove by / Other (please list): | | | | | | | | | | | | | | | | | | | | |
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| PERSONAL HEALTH HISTORY | | | | | | | | | | | | | | | | | | | | |
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| Childhood illness: | | | 🞎 Measles 🞎 Mumps 🞎 Rubella 🞎 Chickenpox 🞎 Rheumatic Fever 🞎 Polio | | | | | | | | | | | | | | | | | |
| **Immunizations?** | | | | 🞎 Tetanus | | | | 🞎 MMR | 🞎 Chickenpox | 🞎 Pneumonia | | | 🞎 Influenza | | 🞎 Hepatitis | | | | | |
| **Current Height:** | | | | | | | |  | **Current Weight:** | | | |  | |  | | | | | |
| WHAT HAVE YOU BEEN SEEN FOR OR TREATED FOR IN THE PAST? PLEASE INCLUDE APPROXIMATE DATES: (Past Medical History) Ex: blood pressure, cholesterol, thyroid, sinus, depression, anxiety, diabetes, arthritis, asthma, allergies, anything you have sought medical help for or taken medication for in the PAST or present. | | | | | | | | | | | | | | | | | | | | |
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| WHAT IS THE PRIMARY REASON FOR YOUR VISIT TODAY? What is the focus of today’s visit—what prompted you to make the appointment? | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | | | |
| Surgeries | | | | | | | | | | | | | | | | | | | | |
| Year | | Reason | | | | | | | | | | | | | Hospital | | | | | |
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| Other hospitalizations | | | | | | | | | | | | | | | | | | | | |
| Year | | Reason | | | | | | | | | | | | | Hospital | | | | | |
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| Have you ever had a blood transfusion? | | | | | | | | | | | | | | | | | 🞎 | Yes | 🞎 | No |

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| FAMILY HEALTH HISTORY | | | | | | | | |
| Adopted: yes / noL=living; D=deceased (include age) | | | | | | | | |
| AGE | Current  age | age at death | | Significant Health Problems & CAUSE OF DEATH IF DECEASED |  | current Age | | Significant Health Problems OR CAUSE OF DEATH IF DECEASED |
| Father |  |  |  | | Children | 🞎 M 🞎 F |  |  |
| Mother |  |  |  | | 🞎 M 🞎 F |  |  |
| Sibling | 🞎 M 🞎 F |  |  | | 🞎 M 🞎 F |  |  |
| 🞎 M 🞎 F |  |  | | 🞎 M 🞎 F |  |  |
| 🞎 M 🞎 F |  |  | | Grandmother Maternal |  | |  |
| 🞎 M 🞎 F |  |  | | Grandfather Maternal |  | |  |
| 🞎 M 🞎 F |  |  | | Grandmother Paternal |  | |  |
| 🞎 M 🞎 F |  |  | | Grandfather Paternal |  | |  |

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| --- | --- |
| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers | |
| Name of the Drug, Strength & Frequency | Vitamins, Herbs, Supplements, etc |
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| Allergies: | |
| DRUGS ALLERGIES: | ENVIRONMENTAL OR FOOD ALLERGIES: |
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| OTHER CURRENT ISSUES |
| Check if you ***currently*** have any symptoms in the following areas to a significant degree and briefly explain. |

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| 🞎 | Skin | 🞎 | Joint Pain |
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| 🞎 | Head/Neck | 🞎 | Muscle pain |
|  |  |  |  |
| 🞎 | Eyes | 🞎 | Dizziness/Loss of Balance |
|  |  |  |  |
| 🞎 | Ears | 🞎 | Numbness/Tingling |
|  |  |  |  |
| 🞎 | Nose | 🞎 | Depression |
|  |  |  |  |
| 🞎 | Throat | 🞎 | Anxiety |
|  |  |  |  |
| 🞎 | Chest/Heart | 🞎 | Blood Sugar Problems |
|  |  |  |  |
| 🞎 | Lungs/Breathing | 🞎 | Thyroid Issues |
|  |  |  |  |
| 🞎 | Intestinal/Bowel | 🞎 | Weight Change |
|  |  |  |  |
| 🞎 | Genital | 🞎 | Changes in Energy |
|  |  |  |  |
| 🞎 | Bladder | 🞎 | Problems with sleep |
|  |  |  |  |
| 🞎 | Circulation/Veins | 🞎 | Other: |
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