Health History Questionnaire

MOUNTAIN RANGE
WELLNESS

Please complete this entire questionnaire. It will provide us with important information about your health. All answers contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____ ☐M ☐F **Date of Birth**:_____

Email: _____ **Phone #**: _____

Primary Care Physician: _____ **Height**: _____ **Weight**: _____ **Age**: _____

Food or Drug Allergies/Sensitivities

Name: _____ Type of Reaction: _____

Name: _____ Type of Reaction: _____

Name: _____ Type of Reaction: _____

☐ I have no known food or drug allergies/sensitivities.

Your Medical History

Please indicate if **you** have a history of any of the following:

- ☐ High cholesterol or lipids
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Liver disease
- ☐ HIV
- ☐ Stroke
- ☐ Heart disease
- ☐ Ulcers
- ☐ Arthritis or joint problems
- ☐ Depression
- ☐ Headaches/migraines
- ☐ Osteoporosis
- ☐ Lung disease (ex:asthma, COPD)
- ☐ Other Disease, Cancer, or Significant Medical Illness
- ☐ NONE of the above

Please list any other past medical problems that may not be included above: _____

_____

Medications

Please list any medications you take regularly (prescription; over the counter; and vitamins):

Drug: _____ Dose/Frequency: _____ Drug: _____ Dose/Frequency: _____

Drug: _____ Dose/Frequency: _____ Drug: _____ Dose/Frequency: _____

Drug: _____ Dose/Frequency: _____ Drug: _____ Dose/Frequency: _____

☐ I take no medications, vitamins, herbals, or any other over-the-counter preparations

Social History

Are you pregnant and/or breastfeeding? ☐Yes ☐ No

Do you exercise? ☐Yes ☐ No

If yes, how often: _____

Please describe your routine:

_____

Do you follow a specific diet? ☐Yes ☐ No

If yes, please describe your diet:

_____

Do you drink alcohol? ☐Yes ☐No

If yes, how much per week? _____

Do you use tobacco? ☐Yes ☐No

If yes, how much per week? _____

Do you use recreational drugs? ☐Yes ☐No

Do you drink caffeine? ☐Yes ☐No

If yes, how much per day? _____

The above information is accurate to the best of my knowledge.

Signature: _____ Date: _____

My preferred method of contact is:

☐Text ☐Phone calls ☐Email