



## HEALTH HISTORY QUESTIONNAIRE

Welcome to Santa Cruz Integrative Medicine! Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the doctor during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Thank you for your help!

First Name: _____ Middle Name: _____ Last Name: _____			
Address: _____ City: _____ State: _____ ZIP: _____			
Home Phone: (____) _____ - _____		Birth Date: ____/____/____ Age: _____ <small>month day year</small>	
Work Phone: (____) _____ - _____		Place of Birth: _____ <small>City or Town &amp; Country, if not US</small>	
Occupation: _____		Height: ____' ____" Weight: _____ Sex: _____	
Referred by: _____		Today's Date _____	

1. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM/DATE OF ONSET	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
<b>Example:</b> Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			

2. Please check appropriate box(es) to indicate your ethnicity:

- African American     Hispanic     Mediterranean     Asian  
 Native American     Caucasian     Northern European     Other

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)  
Example: Wendy, age 7, sister

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4. Do you have any pets or farm animals? Yes\_\_\_\_ No\_\_\_\_

If yes, what kind and where do they live?

A. Indoors \_\_\_\_\_

B. Outdoors \_\_\_\_\_

C. Both in and out \_\_\_\_\_

5. Have you lived or traveled outside of the United States? Yes\_\_\_\_ No\_\_\_\_

If so, when and where? \_\_\_\_\_

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6. Have you or your family recently experienced any major life changes? Yes\_\_\_\_ No\_\_\_\_

If yes, please comment: \_\_\_\_\_

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7. Have you experienced any major losses in life? Yes\_\_\_\_ No\_\_\_\_

If so, please comment: \_\_\_\_\_

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8. How important is religion (or spirituality) for you and your family's life?

a. \_\_\_\_\_ not at all important

b. \_\_\_\_\_ somewhat important

c. \_\_\_\_\_ extremely important

9. How much time have you lost from work or school in the past year?

a. \_\_\_\_\_ 0-2 days

b. \_\_\_\_\_ 3-14 days

c. \_\_\_\_\_ > 15 days

10. Previous jobs: \_\_\_\_\_

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11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

- a. Did you feel safe growing up?  
 Yes       No
- b. Have you been involved in abusive relationships in your life?  
 Yes       No
- c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?  
 Yes       No
- d. Do you currently feel safe in your home?  
 Yes       No
- e. Do you feel safe, respected and valued in your current relationship?  
 Yes       No
- f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?  
 Yes       No
- g. Would you feel safer discussing any of these issues privately?  
 Yes       No

12. Past Medical and Surgical History:

	<b>ILLNESSES</b>	<b>WHEN</b>	<b>COMMENTS</b>
a.	Anemia		
b.	Arthritis		
c.	Asthma		
d.	Bronchitis		
e.	Cancer		
f.	Chronic Fatigue Syndrome		
g.	Crohn's Disease or Ulcerative Colitis		
h.	Diabetes		
i.	Emphysema		
j.	Epilepsy, convulsions, or seizures		
k.	Gallstones		
l.	Gout		
m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		

r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		
	<b>INJURIES</b>	<b>WHEN</b>	<b>COMMENTS</b>
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
	<b>DIAGNOSTIC STUDIES</b>	<b>WHEN</b>	<b>COMMENTS</b>
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X-ray		
am	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X-ray		
aq.	NMR/MRI		
ar.	Sigmoidoscopy		
as.	Upper GI Series		
at.	Other (describe)		
	<b>OPERATIONS</b>	<b>WHEN</b>	<b>COMMENTS</b>
au.	Appendectomy		
av.	Dental Surgery		
aw	Gall Bladder		
ax.	Hernia		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		

13. What medications are you taking now? Include non-prescription drugs.

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

14. Are you allergic to any medications? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

15. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

16. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

17. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

18. How often have you have taken antibiotics?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

19. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

20. As a child, were there any foods that you had to avoid because they gave you symptoms?

Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please: name the food and symptom (Example: milk – gas and diarrhea)

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21. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	

	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Nut butter		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Vegetables		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

22. How much of the following do you consume each week?

a. Candy	
b. Cheese	
c. Chocolate	
d. Cups of coffee containing caffeine	
e. Cups of decaffeinated coffee or tea	
f. Cups of hot chocolate	
g. Cups of tea containing caffeine	
h. Diet sodas	
i. Ice cream	
j. Salty foods	
k. Slices of white bread (rolls/bagels)	
l. Sodas with caffeine	
m. Sodas without caffeine	
n. Regular soda	
o. Juice	
p. Artificial Sweeteners	
q. Restaurant food	
r. Frozen food	
s. Packaged food	
t. Red meat	
u. Lunch meat	

23. Do you salt your food? Yes \_\_\_\_ No \_\_\_\_

24. Are you on a special diet? Yes \_\_\_\_ No \_\_\_\_

\_\_\_\_ ovo-lacto

\_\_\_\_ vegetarian

\_\_\_\_ other (describe):

\_\_\_\_ diabetic

\_\_\_\_ vegan

\_\_\_\_ dairy restricted

\_\_\_\_ blood type diet

25. Is there anything special about your diet that we should know? Yes\_\_\_\_ No\_\_\_\_  
If yes, please explain:

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26. a. Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? Yes\_\_\_\_ No\_\_\_\_

b. If yes, are these symptoms associated with any particular food or supplement(s)?  
Yes\_\_\_\_ No\_\_\_\_

c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

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27. Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.?  
Yes\_\_\_\_ No\_\_\_\_

28. Do you feel much **worse** when you eat a lot of :

_____ high fat foods	_____ refined sugar (junk food)
_____ high protein foods	_____ fried foods
_____ high carbohydrate foods (breads, pastas, potatoes)	_____ 1 or 2 alcoholic drinks
	_____ other _____

29. Do you feel much **better** when you eat a lot of:

_____ high fat foods	_____ refined sugar (junk food)
_____ high protein foods	_____ fried foods
_____ high carbohydrate foods (breads, pastas, potatoes)	_____ 1 or 2 alcoholic drinks
	_____ other _____

30. Does skipping a meal greatly affect your symptoms? Yes\_\_\_\_ No\_\_\_\_

31. Have you ever had a food that you craved or really "binged" on over a period of time?

Food craving may be an indicator that you may be allergic to that food. Yes\_\_\_\_ No\_\_\_\_

If yes, what food(s)? \_\_\_\_\_  
\_\_\_\_\_

32. Do you have an aversion to certain foods? Yes\_\_\_\_ No\_\_\_\_

If yes, what foods? \_\_\_\_\_



39. Are you exposed to second hand smoke regularly? Yes\_\_\_\_ No\_\_\_\_

40. Do you have mercury amalgam fillings? Yes\_\_\_\_ No\_\_\_\_

41. Do you have any artificial joints or implants? Yes\_\_\_\_ No\_\_\_\_

42. Do you feel worse at certain times of the year? Yes\_\_\_\_ No\_\_\_\_

If yes, when? \_\_\_\_spring \_\_\_\_fall \_\_\_\_ summer \_\_\_\_winter

43. Have you, to your knowledge, been exposed to toxic metals in your job or at home?

Yes\_\_\_\_ No\_\_\_\_

If yes, which one(s)? \_\_\_\_lead \_\_\_\_cadmium  
\_\_\_\_arsenic \_\_\_\_mercury  
\_\_\_\_aluminum

44. Do odors affect you? Yes\_\_\_\_ No\_\_\_\_

45. Do you exercise regularly? Yes\_\_\_\_ No\_\_\_\_

a. If so, how many times a week?

- 1. \_\_\_\_ 1x
- 2. \_\_\_\_ 2x
- 3. \_\_\_\_ 3x
- 4. \_\_\_\_ 4x or more

b. When you exercise, how long is each session?

- 1. \_\_\_\_ ≤15 min
- 2. \_\_\_\_ 16-30 min
- 3. \_\_\_\_ 31-45 min
- 4. \_\_\_\_ > 45 min

c. What type of exercise is it?

- \_\_\_\_ jogging/walking \_\_\_\_ tennis
- \_\_\_\_ basketball \_\_\_\_ water sports
- \_\_\_\_ home aerobics \_\_\_\_ other \_\_\_\_\_

46. How well have things been going for you?

	<b>Very Well</b>	<b>Fair</b>	<b>Poorly</b>	<b>Very Poorly</b>	<b>Does not apply</b>
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

47. Have you ever had psychotherapy or counseling? Yes \_\_\_ No \_\_\_  
 Currently? \_\_\_ Previously? \_\_\_ If previously, from \_\_\_ to \_\_\_\_\_.  
 What kind? \_\_\_\_\_  
 Comments: \_\_\_\_\_

48. Are you sexually active? Yes \_\_\_ No \_\_\_  
 When you are sexually active, are you with men \_\_\_\_, women \_\_\_\_ or both \_\_\_\_?  
 Type of birth control? \_\_\_\_\_  
 Any questions/concerns about sexuality? \_\_\_\_\_  
 \_\_\_\_\_  
 Any questions/concerns about your sexual health? \_\_\_\_\_  
 \_\_\_\_\_  
 When you are sexually active, do you enjoy sex? Yes \_\_\_ No \_\_\_  
 If no, why? \_\_\_\_\_  
 Are you able to achieve orgasm? Yes \_\_\_ No \_\_\_  
 Are you in a relationship? \_\_\_\_\_ If yes, or how long with this partner? \_\_\_\_\_  
 If yes, any concerns about your relationship? \_\_\_\_\_  
 Are you currently, or have you ever been, married? Yes \_\_\_\_, # of Marriages \_\_\_\_ No \_\_\_  
 If so, when were you married? \_\_\_/\_\_\_/\_\_\_ Spouse's occupation \_\_\_\_\_  
 When were you separated? \_\_\_\_\_ Never \_\_\_  
 When were you divorced? \_\_\_\_\_ Never \_\_\_  
 When were you remarried? \_\_\_\_\_ Never \_\_\_ Spouse's occupation \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_

49. Hobbies and leisure activities: \_\_\_\_\_  
 \_\_\_\_\_

**For Men Only**

*Please check all that apply to you:*

- |  |   |
|--|---|
| <input type="checkbox"/> Prostate exam ___ / ___ / _____ | <input type="checkbox"/> Abnormal discharge from penis  |
| <input type="checkbox"/> Regular self testicular exam    | <input type="checkbox"/> Pain or lump in scrotum        |
| <input type="checkbox"/> Impaired fertility              | <input type="checkbox"/> Prostate problem               |
| <input type="checkbox"/> Sexual abuse                    | <input type="checkbox"/> Sexually transmitted infection |

**For Women Only**

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Last menses \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last pap smear \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Age menses began \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_  
Number of live births \_\_\_\_\_

*If you are still having periods:*

Average number of days of bleeding \_\_\_\_\_  
Average number of days in cycle \_\_\_\_\_  
Bleeding is \_\_\_ Regular \_\_\_ Irregular  
\_\_\_ Light \_\_\_ Medium \_\_\_ Heavy  
Symptoms \_\_\_ Bleeding b/n periods \_\_\_ Mood swings  
\_\_\_ PMS \_\_\_ Painful menses \_\_\_ Breast tenderness

*If you are no longer having periods:*

\_\_\_ Hot flashes \_\_\_ Vaginal dryness  
\_\_\_ Dry skin \_\_\_ Changes in memory  
and/or  
\_\_\_ Spotting \_\_\_ Changes in libido  
\_\_\_ Facial hair \_\_\_ Changes in mood  
\_\_\_ Hair loss \_\_\_ Hormone replacement therapy  
\_\_\_ Incontinence \_\_\_ Urinary tract infections

*Please check all that apply to you:*

\_\_\_ Hysterectomy \_\_\_ / \_\_\_ / \_\_\_  
\_\_\_ Abnormal pap smear  
\_\_\_ Breast pain / lump / nipple discharge  
\_\_\_ Sexual difficulties  
\_\_\_ Frequent vaginitis / chronic yeast infections  
\_\_\_ Abnormal vaginal discharge  
\_\_\_ Endometriosis  
\_\_\_ Polycystic ovary syndrome  
\_\_\_ Sexually transmitted infection  
\_\_\_ Pelvic inflammatory disease  
\_\_\_ Uterine fibroids  
\_\_\_ Impaired fertility  
\_\_\_ Sexual abuse  
\_\_\_ Regular self breast exam  
\_\_\_ Sexually active  
\_\_\_ Use methods to prevent pregnancy

Sexually Transmitted Infections:

Current: \_\_\_\_\_

Past: \_\_\_\_\_

Completed by \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by Physician \_\_\_\_\_ Date \_\_\_\_\_

**I understand that while seeing the providers at Santa Cruz Integrative Medicine, I also need a primary care physician for emergency care. My current primary care physician's name is**

\_\_\_\_\_.

Name of clinic and address and phone if you know them

\_\_\_\_\_  
\_\_\_\_\_

I am aware that I need a primary care physician for emergency care.

Signed \_\_\_\_\_ Date \_\_\_\_\_

I became aware of Santa Cruz Integrative Medicine, Dr. Abrams, or Dr. Shunney from or through

\_\_\_\_\_.