Anne Jacobs, ND, LAc

Personal Information and Health History Questionnaire

To give you the best possible health care, I need to completely understand your physical, mental and emotional condition. Each health condition you have or have previously had are all interlinked and it is important for you to provide me with as much information as possible. If I have missed something on this form that you think is important, please let me know.
***If you are currently taking any medications or supplements, bring them with you. Please also bring any copies of recent lab work or doctor's reports.**

Full Name: ________________________

Address: __________________________
Street or PO Box

____
City, State, Zip

Phone: _________________________
Home

____
Work and/or Cell

Insurance Co. _________________________

Insurance ID #________________________
(please bring your card to your first appointment)

Date of Birth __________Age____ M or F

Emergency Contact- Name, Address, Phone

____

____

Your Occupation: ___________________

Number of Children: _________________

Marital Status: ☐ Single ☐ Married

☐ Separated ☐ Divorced

With whom do you live?
☐ Spouse ☐Friends
☐Parents ☐Alone
☐Children
☐Other_______________

When did you last go to a doctor's office, medical clinic or hospital? What was the reason?

____

____

____

____

____

____

Please list your most important health concerns:

____

____

____

____

____

____

____

____

____

Signature: ______________________________

Print Name: ____________________________

Date: _________________________________

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HOSPITALIZATIONS OR SURGERIES
What hospitalizations or surgeries have you had?

____

____

____

X-RAYS AND SPECIAL STUDIES
What diagnostic imaging studies have you had?

☐ Electrocardiogram ☐X-Rays

☐Electroencephalogram ☐CT Scan

☐Mammogram ☐MRI

☐Bone Density Scan ☐Other__________

MEDICATIONS, NUTRITIONAL SUPPLEMENTS OR HERBS
Please list current medications and/or supplements And daily dosage or amount taken.

____

____

____

____

____

Please check the box for current use:
☐ Pain Relievers (Aspirin, Tylenol etc)

☐ Diet Pills / Appetite Suppressants

☐ Cortisone (cream or pills)

☐ Thyroid medication

☐ Sleeping pills

☐ Antacids (Rolaids, Tums etc)

☐ Laxatives

☐ Tranquilizers

ALLERGIES
Do you have any allergies to drugs, food, or to the environment (animals, mold, dust, etc)?

☐No ☐Yes
If yes, please explain:

____

____

____

IMMUNIZATIONS
Please mark which of the following immunizations you have had.

☐ Diphtheria ☐ Measles/Mumps/Rubella

☐ Pertussis ☐ Polio ☐ Varicella

☐ Tetanus ☐ Hep B ☐ Flu

☐ Others ______________________________

CHILDHOOD ILLNESSES
Please check the box if you have had any of the following illnesses.

☐ Scarlet Fever ☐ Diphtheria

☐ Rheumatic Fever ☐ Mumps

☐ Measles ☐ German Measles

☐ Chickenpox

☐ Other ______________________________

SELF AND FAMILY HISTORY

Father: Alive? Y N

Age (at death)_______ Cause_______________

If alive, in poor or good health?______________
Mother: Alive? Y N

Age (at death)_______ Cause_______________

If alive, in poor or good health?______________

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SELF AND FAMILY HISTORY CONTINUED

Please check the box for any of the following that you or your family members have experienced.

Anemia	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Asthma	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Arthritis	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Cancer	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Cataracts	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Crohns	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Diabetes	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Gallbladder	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Glaucoma	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Goiter	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Hayfever	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Hives	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Heart Disease	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Hypertension	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Kidney Disease	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Liver Disease	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Mental Illness	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Osteoporosis	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Stroke	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Tuberculosis	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Ulcer	☐ self	☐mother	☐father	☐sister	☐brother	☐children
Ulcerative Colitis	☐ self	☐mother	☐father	☐sister	☐brother	☐children

REVIEW OF SYSTEMS

Y = a condition you have now P= a condition you had in the past N= a condition you never had

Please circle the response that applies.

GENERAL

Weight____________ 1 year ago_____________ Maximum Weight__________ When?_________

SKIN

Rashes	Y N P
Eczema	Y N P
Acnes, Boils	Y N P
Itching	Y N P
Color Change	Y N P
Lumps	Y N P
Night Sweats	Y N P

HEAD

Headache	Y N P
Head Injury	Y N P

EYES

Impaired Vision	Y N P
Glasses or Contacts	Y N P
Eye Pain	Y N P
Tearing or Dryness	Y N P
Double Vision	Y N P
Glaucoma	Y N P
Cataracts	Y N P

EARS

Impaired Hearing	Y N P
Ringing	Y N P
Earache	Y N P
Dizziness	Y N P

BLOOD

Anemia	Y N P
Easy Bleeding	Y N P
Easy Bruising	Y N P
Difficulty Clotting	Y N P

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REVIEW OF SYSTEMS CONTINUED

Y = a condition you have now P= a condition you had in the past N= a condition you never had
Please circle the response that applies.

NOSE & SINUSES
- Frequent colds Y N P
- Nose bleeds Y N P
- Stuffiness Y N P
- Hay Fever Y N P
- Sinus Problems Y N P

MOUTH & THROAT
- Sore throat Y N P
- Sore tongue Y N P
- Gum problems Y N P
- Hoarseness Y N P
- Dental cavities Y N P

NECK
- Lumps Y N P
- Swollen glands Y N P
- Goiter Y N P
- Pain & stiffness Y N P

RESPIRATORY
- Cough Y N P
- Sputum Y N P
- Spitting up blood Y N P
- Wheezing Y N P
- Asthma Y N P
- Bronchitis Y N P
- Pneumonia Y N P
- Pleurisy Y N P
- Emphysema Y N P
- Difficulty breathing Y N P
- Pain on breathing Y N P
- Shortness of breath Y N P
  - At night Y N P
  - Lying down Y N P
- Tuberculosis Y N P

CARDIOVASCULAR
- Heart Disease Y N P
- Angina Y N P
- Hypertension Y N P
- Murmurs Y N P
- Rheumatic fever Y N P
- Chest pain Y N P
- Swelling in ankles Y N P
- Palpitations Y N P
- Flutters Y N P

GASTROINTESTINAL
- Trouble swallowing Y N P
- Change in appetite Y N P
- Nausea Y N P
- Vomiting Y N P
- Vomiting blood Y N P
- Bowel movements
  - How often__________
  - Is this a change?______
- Blood in stool Y N P
- Belching or gas Y N P
- Jaundice Y N P
- Liver disease Y N P
- Hemorrhoids Y N P

URINARY
- Pain on urination Y N P
- Increased frequency Y N P
- Frequency at night Y N P
- Inability to hold Y N P
- Frequent infections Y N P
- Kidney stones Y N P

FEMALE ONLY
- Age menses began_______
- Number of days_________
- Length between cycles____
- Any spotting Y N P
- Regular cycles Y N P
- Pain w/ intercourse Y N P
- Painful menses Y N P
- Excessive flow Y N P
- Birth control Y N P
- What type?_____________
- # of pregnancies________
- # live births____________
- # of miscarriages________
- # of abortions__________
- Difficulty conceiving Y N
- Menopausal Y N P
  - Symptoms? Y N P
- Sexually active Y N P
- Sexual preference
  - ☐ Heterosexual
  - ☐ Homosexual
  - ☐ Bisexual
- Do you do self-breast exam? Y N P

FEMALE ONLY
- Breast lumps Y N P
- Pain or tenderness Y N P
- Nipple discharge Y N P
- Vaginal discharge Y N P

MALE ONLY
- Hernias Y N P
- Testicular mass Y N P
- Testicular pain Y N P
- Sexually active Y N P
- Sexual difficulties Y N P
- Prostate disease Y N P
- Venereal disease Y N P
- Discharge or sores Y N P
- Sexual preference
  - ☐ Heterosexual
  - ☐ Homosexual
  - ☐ Bisexual

MUSCULOSKELETAL
- Joint pain Y N P
- Stiffness Y N P
- Arthritis Y N P
- Broken bones Y N P
- Muscle spasms Y N P
- Weakness Y N P

PERIPHERAL VASCULAR
- Deep leg pain Y N P
- Cold hands/feet Y N P
- Varicose veins Y N P
- Thrombophlebitis Y N P

NEUROLOGIC
- Fainting Y N P
- Seizures Y N P
- Paralysis Y N P
- Muscle weakness Y N P
- Numbness/tingling Y N P
- Loss of memory Y N P

EMOTIONAL
- Depression Y N P
- Mood Swings Y N P
- Anxiety/nervous Y N P
- Tension Y N P
- Bipolar Y N P
- Other?________________

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REVIEW OF SYSTEMS CONTINUED
Y = a condition you have now P= a condition you had in the past N= a condition you never had
Please circle the response that applies.

ENDOCRINE
Hypothyroid Y N P
Heat intolerance Y N P
Cold intolerance Y N P
Excessive thirst Y N P
Excessive hunger Y N P

HABITS
Watch TV Y N
How many hours per day_______________
Read Y N
How many hours per day_______________
Exercise Y N P
How many days/week____
What type? _____________
____
Spend time outside Y N
Take vacations Y N
Awake rested Y N
Sleep well Y N
Avg. 6-8 hours Y N
Use recreational drugs Y N
Use tobacco Y N
How many cigarettes per day____________
Drink alcohol Y N
How many drinks per week______________
Drink coffee Y N
How many cups per day_______________
Drink soda or pop Y N
How many bottles per day_______________

DIET
Eat 3 meals/day Y N
Eat snacks Y N
Have you been on a weight loss diet in the last year? Y N
Do you avoid any foods
____
____
____
Buy organic food ? Y N

Are you vegan or vegetarian (circle one)

CANCER DIAGNOSIS ONLY
Please tell me about your cancer diagnosis (type, stage, date of diagnosis etc).

____

____

Please tell me what treatments you have done or will be doing.

____

____

Please describe any side effects you might be experiencing either from the cancer or treatment.

____

____

Please tell me anything else you'd like me to know about your diagnosis.

____

____

Thank you for taking the time and effort to fill this out as correctly and accurately as possible. By signing you certify that the answers you provided are accurate and correct to the best of your knowledge.

Signature____

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