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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