



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.

Legal Name: _____

Preferred Name: _____

Pronouns Used: _____

Address: _____
Street or PO Box

City, State, Zip

Phone: _____
Cell/Home/Work (circle one)

Insurance Co. _____
(please bring your card to your first appointment)

Date of Birth _____ Age _____ M/F/O

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: _____



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? _____

Anne Jacobs, ND, LAc



SELF AND FAMILY HISTORY CONTINUED

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

Anemia	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Asthma	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Arthritis	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Cancer	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Cataracts	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Crohns	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Diabetes	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Gallbladder	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Glaucoma	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Goiter	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Hayfever	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Hives	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Heart Disease	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Hypertension	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Kidney Disease	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Liver Disease	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Mental Illness	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Osteoporosis	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Stroke	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Tuberculosis	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Ulcer	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	children
Ulcerative Colitis	<input type="checkbox"/>	self	<input type="checkbox"/>	mother	<input type="checkbox"/>	father	<input type="checkbox"/>	sister	<input type="checkbox"/>	brother	<input type="checkbox"/>	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

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

BLOOD

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

HEAD

Headache Y N P
Head Injury Y N P

EARS

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



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
Stiffness 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
Flutter 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 _____

Phone: 207-523-9247
Fax: 207-563-1471

e-mail: anne@drannejacobs.com
www.drannejacobs.com