Susan Stone, DOM, AP | Jane Pasienza, DOM, AP

804 40th Street West
Bradenton, FL. 34205

941-896-9746

STONE WELLNESS
the art of balance

Confidential Health History Questionnaire

Last Name	First Name	Middle Initial

Street Address	City	State	Zip

Home Phone	Cell Phone	Date of Birth	Age	Sex	Marital Status

Work Phone	Employer	Occupation	Email Address

Emergency Contact Name	Phone Number	Relationship to you

Primary Medical Doctor	City	Phone

How Did You Hear About Us?	Friend/Family Member? Name:	Internet?	Other _____

Please list your reason(s) for coming to see us, summarizing any health concerns you have along with what treatments have you tried for these conditions, if any?

_____

Please list your current medicines, dosages & reasons:

Height	Weight	Blood Pressure (If Known)	Blood Type (If Known)

Please check the box if you are experiencing any of the following:

Digestive:

❒Abdominal/stomach pain ❒Abnormal appetite ❒Belching ❒Black stool
❒Blood in stool ❒Constipation ❒Diarrhea ❒Heartburn/reflux
❒Gas ❒Mucous in stool ❒Nausea ❒Overweight
❒Rectal pain ❒Regular laxative use ❒Unusually thirsty ❒Undigested food in stool
❒Vomiting ❒Weight changes

Body Temperature:

❒Chills ❒Excessive sweating ❒Tendency to be too hot ❒Fever
❒Hot flashes ❒Lack of perspiration ❒Night Sweats ❒Tendency to be too cold

Circulatory:

❒Bleeding/bruising easily ❒Bleeding gums ❒Cold hands/feet ❒Dizzy spells or fainting
❒Irregular heart beat ❒Palpitations/chest fluttering ❒Poor circulation ❒Pounding heart beat

Eyes/Ear/Nose/Throat:

❒Dry eyes ❒Tearing eyes ❒Dry mouth or throat ❒Earaches ❒Eye pain
❒Facial pain ❒Frequent hoarseness ❒Frequent sore throat ❒Headaches ❒Hearing problems
❒Itchy Eyes ❒Jaw Problems or TMJ ❒Cavities/Root Canals ❒Mouth or lip sores
❒Night or color blindness ❒Nose bleeds ❒Teeth grinding or clenching
❒Unusual taste in mouth ❒Sinus problems ❒Sneezing ❒Snoring
❒Swollen glands

Upper Respiratory

❒Coughing blood ❒Chronic Cough ❒Frequent chest colds ❒Frequent Bronchitis
❒Shortness of breath ❒Tightness of chest ❒Wheezing
❒Allergies (If so to what?)_____

Energy Level:

❒Chronic infections ❒Fatigue or tiredness ❒Sudden energy drop.....(time of day_____)

Mood:

❒Anger ❒Anxiety ❒Depression ❒Fear ❒Frustration
❒Grief or sadness ❒Irritability ❒Mood swings ❒Obsession ❒Panic Attacks

Urinary:

❒Blood in urine ❒Burning or painful urination ❒Difficult urination/retention
❒Difficult urination/retention ❒Frequent or urgent urination ❒Frequent urination at night
❒Loss of bladder control

Skin:

❒Acne/pimples ❒Dry skin ❒Itching or burning skin ❒Skin rash, psoriasis or eczema
❒Skin sores ❒Dandruff or flaking ❒Early graying of hair ❒Loss of hair
❒Nail fungus ❒Weak/brittle nails ❒Nails or hair that won't grow

Pain:

❒Back pain or trouble ❒ Neck Pain ❒Muscle spasm or cramps ❒Muscle weakness
❒Numbness/tingling ❒Pain of feet ❒Restless or nervous legs ❒Sciatica
❒Spinal disc problems ❒Swelling ❒Tendonitis (where_____)

Sleep:

❒Difficulty sleeping thru night ❒Difficulty falling asleep ❒Night sweats or heat ❒Painful Sleep
❒Sleep Apnea ❒Vivid dreams ❒Wake up still tired

Circulatory:

❒Numbness or tingling ❒Poor concentration ❒Poor memory ❒Seizures or convulsions
❒Shaking or trembling ❒Stuttering or stammering

FOR MEN:

❒Genital pain, swelling or itching ❒Impotence ❒Low Sperm Count ❒ Low Libido
❒Prostate Problem (_____)

FOR WOMEN:

❒Abortion ❒Miscarriage ❒Difficulty conceiving ❒Abnormal PAP smear

❒PMS ❒Painful periods ❒Bleeding between periods ❒Heavy bleeding w/periods

❒Clots in menstrual blood ❒Polycystic ovary disease ❒Pelvic Inflam. Disease

❒Fibroids ❒Endometriosis ❒Breast lumps/tenderness ❒Ovaries removed

❒Hysterectomy ❒Menopausal symptoms ❒Abnormal sex drive

❒Pain with intercourse ❒Vaginal discharge ❒Vaginal dryness

Duration of periods:_____ Number of pregnancies:_____

Interval between periods:_____ Number of births:_____

Dates of last period:_____ Ages of children:_____

Past birth control methods:_____ Current birth control method:_____

OBGYN:_____

Check if you have had any of these:

❒Addiction (to_____)
❒AIDS/HIV
❒Allergies
❒Anemia
❒Arthritis
❒Asthma
❒Bleeding Disorder
❒Blood clots
❒Bronchitis
❒Cancer/tumor
❒Cataracts
❒Chicken Pox
❒Chronic fatigue
❒Colon/bowel disease
❒Diabetes
❒Emotional/mental problem
❒Emphysema
❒Fibromyalgia
❒Gallbladder disease/stones
❒German measles
❒Glaucoma
❒Gum disease
❒Heart disease
❒Hemorrhoids
❒Hepatitis or jaundice
❒Herpes
❒High/Low Blood pressure
❒High Cholesterol
❒Kidney Stones
❒Kidney or bladder infections
❒Liver Disease
❒Lupus
❒Malaria
❒Measles
❒Mononucleosis
❒Multiple sclerosis
❒Mumps
❒Osteopenia/osteoporosis
❒Pleurisy
❒Pneumonia
❒Polio
❒Rheumatic fever
❒Scarlet fever
❒Shingles
❒Spinal meningitis
❒Stroke
❒Tuberculosis
❒Thyroid trouble/Goiter
❒Ulcer
❒Varicose Veins
❒Venereal Disease

Other specific illnesses:

Check if you have a FAMILY HISTORY of any of these:

❒	Allergies	❒	Epilepsy	❒	Mental illness
❒	Arthritis	❒	Glaucoma	❒	Problem with alcohol or drugs
❒	Asthma	❒	Gout	❒	Stroke
❒	Bleeding disorders	❒	Heart disease	❒	Thyroid disease
❒	Cancer	❒	High blood pressure	❒	Other inheritable disease:
❒	Diabetes	❒	Kidney disease	❒	

Health Habits:

Smoke Cigarettes? Yes____ No_____ Did, but quit _____ How did you quit?_____

Use Recreational Drugs? Yes_____ No_____

Drink Alcohol? Yes_____ No_____ If yes, how often?_____

Have an addiction? Yes_____ No_____ If yes, to what and for how long?_____

Drink Water? Yes_____ No_____ If yes, how many ounces per day?_____

Drink Soda? Yes_____ No_____ If yes, what type and how many? Per week _____

Take Supplements? Yes_____ No_____ If yes, what and how often?

_____

_____

Exercise? Yes_____ No_____ If yes, how and how often?_____

Diet:

(On a scale of 1-5 how many servings of the following foods are in your daily diet?)

❒ Meat_____ ❒ Vegetables_____ ❒ Fruit_____ ❒ Breads(Gluten)_____

❒ Starch (i.e. potatoes, beans)_____ ❒ Sugar_____ ❒ Fried Foods_____

❒ Fast Food_____❒ Processed Food_____❒ Sweet Tea_____

List any surgeries/hospitalizations and date of:

Sign:	Date: