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EUROPEAN WELLNESS™

HEALTH QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

GUEST NAME: _____

GUEST DATE OF BIRTH: _____ **TODAY'S DATE:** _____

AGE: _____ **CURRENT WEIGHT:** _____ **CURRENT HEIGHT:** _____

GENDER: M / F **BLOOD TYPE:** _____ **MARITAL STATUS:** _____

What would you like to talk to your doctor about today?

_____

_____

MEDICAL HISTORY

Please list any medication allergies or reactions:

_____

_____

Please check to indicate if you have ever had the following conditions:

- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Kidney disease
- ☐ Arrhythmia
- ☐ Depression
- ☐ Thyroid disease
- ☐ Congestive heart failure
- ☐ Stroke
- ☐ High blood pressure
- ☐ Coronary artery disease
- ☐ Heart attack

- ☐ Sexually transmitted diseases – type: _____
- ☐ Eye problem –type: _____
- ☐ Cancer – type: _____
- ☐ Others, please explain: _____

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery / reason for hospitalization / location *Date*

_____ _____

_____ _____

_____ _____

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

_____

_____

When was your last medical check-up?

_____

Please list all medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.

Medication Name *Dosage*

_____ _____

_____ _____

_____ _____

Which pharmacy do you visit for prescription medications?

_____

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Are you currently receiving care from any other doctors, chiropractors, or other health care professionals?

If yes, we would like to know whom so that we can coordinate your care:

Provider's name	*Condition they are treating you for*
_____	_____
_____	_____
_____	_____

Please note your most recent immunizations dates:

Approximate Date

Tetanus:_____ Influenza:_____

Hepatitis B:_____ Others:_____

If you have had any of the following tests done, please note when the tests were done and what the results were, if known:

Test	*Approximate date*	*Result*
Cholesterol	_____	___
Pap smear/pelvic	_____	___
Mammogram	_____	___
Blood in stool	_____	___
HIV	_____	___
Colonoscopy	_____	___
Hepatitis C	_____	___

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FAMILY HISTORY

Check any of the diseases that runs in your family **and** please note who had it:

	None	Mother	Father	Sister	Brother	Grandmother (maternal)	Grandfather (maternal)	Grandmother (paternal)	Grandfather (paternal)	Children	Others (Please explain)
Alcoholism or Drug Use	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer Type	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Others	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Other Comments:

_____

_____

_____

_____

_____

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HEALTH HABITS

Are you on a certain diet or food plan? ☐ Regular diet ☐ Vegetarian

Do you smoke or use any tobacco products? ☐ Yes ☐ No ☐ Quitted

Number of cigarettes each day? _____

For how many years? _____

Other forms of tobacco use _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Quitted

How much? _____

How often? _____

Have you ever felt that you should cut down on your drinking? ☐ Yes ☐ No

Do you often use other drugs (street drugs)? ☐ Yes ☐ No

If yes, are you still using them? ☐ Yes ☐ No

SEXUAL HISTORY

Are you sexually active? ☐ Yes ☐ No

With

☐ Male
☐ Female
☐ Both

Do you have children? ☐ Yes ☐ No

How many children do you have? _____

Do you use any form of birth control? ☐ Yes ☐ No

_____

If yes, which type/brand?

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WOMEN ONLY

Have you ever been pregnant? ☐ Yes ☐ No

How many times? _____

Do you still have menstrual periods? ☐ Yes ☐ No

If no, at what age did it stop? _____

If yes, are your periods regular? ☐ Yes ☐ No

OTHER COMMENTS

_____

_____

_____

_____

_____