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<b>Original Date:</b>
<b>Dates Revised:</b>

## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

<b>Name</b> <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	<b>Date Of Birth:</b>
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>Current or referring doctor:</b>		<b>Date of last physical exam:</b>	

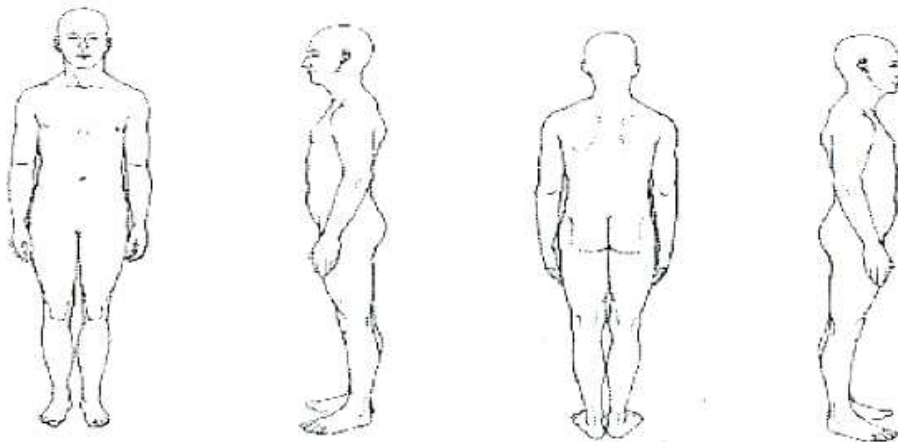
Please fill out the following information as accurately as possible. This will help the doctor with diagnosis and treatment plan.

Please, list specific health concerns **in the order of importance** to you:

Health concern	Date started	Diagnosis given	Treatments received

Do you have any insights about your health concerns? \_\_\_\_\_

Please circle the location of your discomfort on the model below:





## HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
	Type of exercise you do and how often: _____		
<b>Diet</b>	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank <u>s</u> alt intake:	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	
	Rank <u>f</u> at intake:	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	
<b>Caffeine</b>	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soft Drinks		
	# of cups/cans per day?		
<b>Alcohol</b>	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
<b>Drugs</b>	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sex</b>	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	List all contraceptive or barrier methods used (if applicable): _____		
	Any discomfort with intercourse?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Personal Safety</b>	Do you live alone?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Would you like information on the preparation of these?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?		<input type="checkbox"/> Yes <input type="checkbox"/> No

## FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Paternal</i>		

### MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### WOMEN ONLY

Age at onset of menstruation: _____		
Date of last menstruation: _____		
How many days in a regular cycle? _____		
Heavy periods, irregularity, spotting, pain, or discharge (circle any or all)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam? _____		

### MEN ONLY

Do urinate at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times _____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam? _____		

### OTHER PROBLEMS

Check the condition below if it is a current issue, or if it has been an issue in the past (P=Past, C=Current).

#### **General**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Poor appetite             | <input type="checkbox"/> Tremors               |
| <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Localized weakness        | <input type="checkbox"/> Poor balance          |
| <input type="checkbox"/> Fever                 | <input type="checkbox"/> Bleed or bruise easily    | <input type="checkbox"/> Frequent cold/flu     |
| <input type="checkbox"/> Weight loss _____ lbs | <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Weight gain _____ lbs |
| <input type="checkbox"/> Sweat easily          | <input type="checkbox"/> Strong thirst             | <input type="checkbox"/> Alcoholism            |
| <input type="checkbox"/> Night sweats          | <input type="checkbox"/> Cravings                  | <input type="checkbox"/> Drug addiction        |
| <input type="checkbox"/> Chills                | <input type="checkbox"/> Poor sleep habits         | <input type="checkbox"/> Other                 |

#### **Skin and Hair**

- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> Rashes                      | <input type="checkbox"/> Psoriasis     | <input type="checkbox"/> New moles  |
| <input type="checkbox"/> Itching                     | <input type="checkbox"/> Acne          | <input type="checkbox"/> Hair loss  |
| <input type="checkbox"/> Dandruff                    | <input type="checkbox"/> Eczema        | <input type="checkbox"/> Hives      |
| <input type="checkbox"/> Change in hair/skin texture | <input type="checkbox"/> Nail problems | <input type="checkbox"/> Open sores |
| <input type="checkbox"/> Dry skin                    | <input type="checkbox"/> Jaundice      | <input type="checkbox"/> Other      |

#### **Head, Eyes, Ears, Nose and Throat**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Dizziness/Vertigo   | <input type="checkbox"/> Concussions        | <input type="checkbox"/> Migraines              |
| <input type="checkbox"/> Poor vision         | <input type="checkbox"/> Eye strain         | <input type="checkbox"/> Eye pain               |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Night blindness    | <input type="checkbox"/> Color blindness        |
| <input type="checkbox"/> Ringing in ears     | <input type="checkbox"/> Blurry vision      | <input type="checkbox"/> Earaches               |
| <input type="checkbox"/> Sinus problems      | <input type="checkbox"/> Poor hearing       | <input type="checkbox"/> Spots in vision        |
| <input type="checkbox"/> Teeth grinding      | <input type="checkbox"/> Nose bleeds        | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Nasal congestion    | <input type="checkbox"/> Hoarseness         | <input type="checkbox"/> Facial pain            |
| <input type="checkbox"/> Discharge from eyes | <input type="checkbox"/> Mouth or lip sores | <input type="checkbox"/> Headaches: Where _____ |

#### **Cardiovascular**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chest pain/discomfort     | <input type="checkbox"/> Blood clots          |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Bleeding disorder         | <input type="checkbox"/> Cold hands/feet      |
| <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Swelling of hands or feet | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Fainting                  | <input type="checkbox"/> Varicose veins       |
| <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Other _____               |   |

#### **Respiratory**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cough                           | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Pain w/ deep breath |
| <input type="checkbox"/> Bronchitis                      | <input type="checkbox"/> Pneumonia      | <input type="checkbox"/> Phlegm              |
| <input type="checkbox"/> Difficulty breathing lying down | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Other: _____        |

#### **Gastrointestinal**

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Nausea                   | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Diarrhea     |
| <input type="checkbox"/> Vomiting                 | <input type="checkbox"/> Flatulence           | <input type="checkbox"/> Belching     |
| <input type="checkbox"/> Bad Breath               | <input type="checkbox"/> Blood in Stools      | <input type="checkbox"/> Black Stools |
| <input type="checkbox"/> Abdominal Pain or Cramps | <input type="checkbox"/> Rectal Pain          | <input type="checkbox"/> Hemorrhoids  |
| <input type="checkbox"/> Indigestion              | <input type="checkbox"/> Chronic Laxative Use | <input type="checkbox"/> Acid Reflux  |
| <input type="checkbox"/> Ulcer                    | <input type="checkbox"/> Colitis              | <input type="checkbox"/> Other: _____ |

