

ALBERT L. HIRSCH, M.D.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

DEMOGRAPHICS

Date: _____

Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status: Single Married Separated Divorced Occupation: _____

Emergency Contact: _____ Phone: _____

Insurance Company: _____ Address: _____

Subscriber ID: _____ Group #: _____

FAMILY MEDICAL HISTORY

Significant Health Problems

Father _____ Age _____

Mother _____ Age _____

Siblings _____ Age _____

Siblings _____ Age _____

PERSONAL HEALTH HISTORY

Date of last physical: _____ Current weight: _____ Ideal Weight: _____

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain below.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Pituitary Disorder | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Premenstrual Syndrome | Have you recently had |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Dehydration |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke | <input type="checkbox"/> Fever/Chills |
| <input type="checkbox"/> Emotional Disorder | <input type="checkbox"/> Kidney Conditions | <input type="checkbox"/> Thyroid Conditions | <input type="checkbox"/> Nausea/Vomiting |

Other health conditions/explanations:

Surgeries/Hospitalizations (please list year/reason):

PERSONAL HEALTH HISTORY CONTINUED

Do you have any drug allergies? (Please list)

Do you take any prescriptions medications? (Please list):

Name of Drug	Strength	Frequency taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any non-prescription drugs, vitamins or supplements? (Please list):

Name	Strength	Frequency taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? (Please list):

Are you currently under the care of other physicians? Yes No (Please check type of practitioners seen)

Primary Care OB/GYN Chiropractor Podiatrist Naturopath Other _____

How would you rank your stress level? (Please circle): Low Medium High

What do you consider your main source of stress: _____

Do you often feel guilty about past mistakes? (Please circle) Yes No

Do you worry about the future? (Please circle) Yes No Do you feel depressed? Yes No

Describe a typical nights sleep: _____

Do you take anything to help you sleep? (Please list) _____

Do you fall asleep easily? Yes No Do you have difficulty staying asleep? Yes No

How many hours of good sleep do you average? _____ Do you typically dream? Yes No

What is your regular bedtime? _____ What time do your regularly awaken? _____

Do you feel rested in the morning? Yes No Do you feel tired in the afternoon? Yes No

What time is your last meal? _____ Do you snack before bedtime: Yes No If yes, what?

HEALTH HABITS

Exercise (Please check):

- Sedentary (no exercise)
- Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
- Occasional vigorous exercise (less than 4x/week for 30 min.)
- Regular vigorous exercise (more than 4x/week for 30 min.)
- Athlete If so, recreational or competitive.

Do you smoke? (Please circle) Yes No If yes, _____ per day/week/month

Do you drink alcohol?(Please circle) Yes No If yes, what type? _____

How often? _____ per day/week/month

NUTRITION

How would you describe your diet currently? _____

Do you follow someone's nutrition advice? Yes No Whose? _____

Are you on a special diet or nutrition plan? Yes No If yes, please describe _____

Do you feel that you are trying to eat healthy? Yes No What % of the time? _____

Do you feel you are succeeding? Yes No

Do you eat from habit and enjoyment or for fuel and health? _____

How much water do you drink a day? _____

What other non-alcoholic beverages do you drink on a regular basis? (Please check)

- Soda (Please circle) Diet Regular How much? _____
- Coffee (Please circle) Regular Decaf How much? _____
- Tea What kind? _____ How much? _____
- Fruit Juice What Kind? _____ How much? _____
- Milk (Please circle) Regular 1% 2% Skim Rice Almond How much? _____

NUTRITION CONTINUED

What types of oils do you use/consume?

- | | | | |
|--------------------------------------|---------------------------------------|--|--|
| <input type="checkbox"/> Butter | <input type="checkbox"/> Peanut Oil | <input type="checkbox"/> Peanut Oil | <input type="checkbox"/> Sun/Safflower Oil |
| <input type="checkbox"/> Margarine | <input type="checkbox"/> Flaxseed Oil | <input type="checkbox"/> Corn Oil | <input type="checkbox"/> Crisco |
| <input type="checkbox"/> Olive Oil | <input type="checkbox"/> Sesame Oil | <input type="checkbox"/> Vegetable Oil | <input type="checkbox"/> Mayonnaise |
| <input type="checkbox"/> Coconut Oil | <input type="checkbox"/> Soybean Oil | <input type="checkbox"/> Canola Oil | <input type="checkbox"/> Other _____ |

How many meals do you eat per day including snacks? _____

Typically what do you eat (meals & snacks)? _____

Do you eat breakfast? Yes No If yes, how long after awakening? _____

What do you eat for breakfast? _____ How often do you eat breakfast? _____

Do you eat fast food? Yes No If yes, how often _____

Do you feel you overeat? Yes No

Do you binge eat at times? Yes No

Do you typically eat everything on your plate? Yes No

Do you eat bread or rolls with your meal? Yes No If yes, do you use butter/margarine? Yes No

Do you feel full after meals? Yes No

Do you drink with meals? Yes No If yes, what? _____

Do you eat for "comfort" when you are stressed or sad? Yes No

Do you have sugar or carbohydrate cravings? Yes No

How often do you eat dessert? _____

Do you eat fruits and/or vegetable? Yes No If yes, how often? _____

HORMONE EVALUATION

Check if you have, or have had, any of the following symptoms.

- | | | |
|--|---|---|
| <input type="checkbox"/> Thinning Hair | <input type="checkbox"/> Tired During the Day | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Fragile or Thinning Skin | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Joint Pain, Numbness, or Tingling | <input type="checkbox"/> Dry or Brittle Hair or Nails | <input type="checkbox"/> Poor Muscle Mass |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Discomfort During Sex | <input type="checkbox"/> Decreased Libido |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Weight Gain/Loss, Abdominal Fat | <input type="checkbox"/> Uncomfortable Body Temperature (Hot or Cold) | |

WOMEN ONLY

Date of last menstruation: _____ Date of last pap smear: _____

Date of last mammogram: _____ Results: _____ Date of last bone density: _____ Results: _____

What type of birth control do you use? _____

Are you having regular menstrual cycles? If not, due to: birth control, surgery or menopause?

If surgery, do you still have your ovaries? _____

Do you have heavy periods, irregularity, spotting pain or discharge? Yes No

Do you have hot flashes or night sweats? Yes No

Do you feel that you are having symptoms of hormone deficiency? Yes No If yes, please specify

Are you sexually active? Yes No If yes, please proceed with this section. If no, why not?

How is your libido? (Please rate. 1 none, 5 excellent.) 1 2 3 4 5

Are you satisfied with how your body functions during sexual activity? Yes No

The following questions are optional, if you want this issues address.

Do you have pain with intercourse? Yes No

Do you use lubricant with intercourse? Yes No

Do you feel that you and your partner communicate well enough to optimize the experience for both of you?

Yes No

MEN ONLY

Are you sexually active? Yes No

How is your libido? (Please rate. 1 none, 5 excellent.) 1 2 3 4 5

Do you take ED medications? Yes No If yes, necessary or recreational? _____

Do you awaken at night or in the morning with penile erections, even partial? Yes No

Are you satisfied with how your body functions during sex? Yes No

Do you have any urinary symptoms? Yes No

Do you have difficulty getting motivated to exercise? Yes No

Does your body respond well to exercise? Yes No