ALBERT L. HIRSCH, M.D.
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

Please complete this form to the best of your ability.

Last Name	First	Date of Birth	Age	Marital Status
Address	City	State	Zip	
Home Phone	Cell Phone		Email	
Spouse's Name	Cell Phone		Email	
Emergency Contact	Phone		Email	
Insurance Company	Subscriber ID	Group #		
Main Reason for Visit			Referred By	
Height	Weight	Goal Weight	Lowest Adult Weight (after age 18)	

MEDICAL HISTORY

Alcohol Abuse		Gout		Prostate Problems	
Anemia		Heartburn/Indigestion		Seizures	
Arthritis		Heart Disease		Sleep Apnea	
Asthma		Hepatitis		Stroke	
Autoimmune Problems		High Blood Pressure		Thyroid Disorder	
Blood Clots		High Cholesterol		Tumors	
Cancer (type:)		Insomnia		Ulcers	
Depression or Anxiety		Kidney Conditions			
Diabetes		Menopause Symptoms		**Have you recently had**	
Difficult Pregnancies		Migraines		Dehydration	
Dizziness		Obesity/Overweight		Diarrhea	
Drug Abuse		PCOS		Fever/Chills	
Eating Disorder		Pituitary Disorder		Nausea/Vomiting	

Other Medical Problems Not Listed Above:

_____

_____

_____

FAMILY MEDICAL HISTORY

Relation	Age	Significant Health Problems
Father		
Mother		
Siblings		
Siblings		

SURGERIES & HOSPITALIZATION

Reason/Diagnosis	Year	Reason/Diagnosis	Year

COSMETIC PROCEDURES

	Date		Date

WEIGHT OR FAT LOSS PROCEDURES

Type (lap Band, liposuction, gastric bypass, etc.)	Date	Results

MEDICATION ALLERGIES ☐ *NO KNOWN ALLERGIES*

Name of Medication	Reaction	Name of Medication	Reaction

PRESCRIPTION MEDICATIONS

Medication Name	Dose & Frequency	Approx. Start Date	Reason for Use

SUPPLEMENTS & OVER-THE-COUNTER MEDICATIONS

Supplement/Medication Name	Dose & Frequency	Approx. Start Date	Reason for Use

SCREENING

Test	Last Date Done	Results (-) or state findings
Bone Density		
Colonoscopy		
Complete Physical		
PAP Smear (women)		
Mammogram (women)		
Prostate exam (men)		

PERSONAL HISTORY

Are you currently under the care of other physicians? □ Yes □ No

Type: □ Primary Care □ OB/GYN □ Chiropractor □ Naturopath □ Other

Occupation: Stress Level (1-10) What do you consider your main source of stress?

Have you ever been diagnosed with an autoimmune disorder? If yes, what type?

□ Yes □ No

Do you often feel guilty about past mistakes? Do you worry about the future? Do you feel depressed?

□ Yes □ No □ Yes □ No □ Yes □ No

Describe a typical night's sleep: How many good hours of sleep do you average a night?

When is your regular bedtime? When do you usually awaken?

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

Do you fall asleep easily? Do you have difficulty staying asleep?

□ Yes □ No □ Yes □ No

Do you dream? Do you snore loudly?

□ Yes □ No □ Yes □ No

Do you feel rested in the morning? Do you feel tired in the afternoon?

□ Yes □ No □ Yes □ No

What time is your last meal? Do you snack before bedtime?

□ Yes □ No If yes, what?

HEALTH HABITS

Activity Level

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

Describe your exercise routine. How long have you been following this regimen?

Alcohol use: □ Yes □ No If yes, what kind: How many drinks per day/week/month
Tobacco use: □ Yes □ No Past use-quit date: _____ If yes, number of years total_____ Number of: Cigarettes/day Cigar/day Chew/day Pipe/day
Recreational drug use: □ Yes □ No If yes, type?

HORMONE EVALUATION

	None	Mild	Moderate	Severe
Insomnia				
Depression				
Tired During the Day				
Fatigue				
Thinning Hair				
Fragile or Thinning Skin				
Dry or Brittle Hair or Nails				
Constipation				
Sexual Dysfunction				
Joint Pain, Numbness, or Tingling				
Osteoporosis of Osteopenia				
Weight Gain/Loss. Excess Abdominal Fat				
Discomfort During Sex				
Poor Motivation				
Brain "Fog"-Memory/Concentration Loss				
Decreased Libido				
Poor Muscle Mass				
Uncomfortable Body Temperature (Hot or Cold)				
Prolonged Soreness after Exercise				
Difficulty Awakening Fully				

FEMALE PATIENTS

Last Menstrual Period: Age of First Onset of Period:
Number of Children Ages Any health problems?
Did you have difficulty conceiving? Natural or IVF conception? C-Section? □ Yes □ No
What type of contraception do you use? If IUD, what kind? Does it release hormones?
If still menstruating: cycle every _____ days Circle if (+): Heavy periods, irregularity, spotting or pain
If no longer menstruating, due to birth control, surgery, menopause, or other If surgery what kind (hysterectomy, tubal ligation etc.)? _____ Do you still have your ovaries? □ Yes □ No
Do you feel you are having symptoms of hormone deficiency? □ Yes □ No If yes, please specify

Have you ever been told that you have or may have PCOS? □ Yes □ No

Do you or have you had any of the following symptoms?

Obesity □ Yes □ No
Acne or unwanted hair growth that started as early as the first few years after beginning menses □ Yes □ No
Severe PMS □ Yes □ No
Irregular, absent or difficult menstrual cycles □ Yes □ No
Difficulty getting pregnant □ Yes □ No Received Metformin or Progesterone to aid in conception □ Yes □ No
History of miscarriages □ Yes □ No How many times? _____
Insomnia, depression or anxiety □ Yes □ No
Thinning scalp hair □ Yes □ No
Unusually high libido at times □ Yes □ No
Development of masculine features □ Yes □ No
Weight gain in spite of good nutrition and exercise □ Yes □ No
Sugar and/or carb craving □ Yes □ No
Ovarian cysts □ Yes □ No
Cholesterol abnormalities □ Yes □ No

Did you have difficult pregnancies □ Yes □ No If yes, describe

Are you sexually active? □ Yes □ No 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 these issues addressed.

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

MALE PATIENTS

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 sometimes awaken during the night or in the morning with penile erections, even partial? □ Yes □ No

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

Do you have any urinary symptoms? □ Yes □ No If yes, please describe:

Do you have difficulty getting motivated to exercise? □ Yes □ No

Does your body respond well to exercise? □ Yes □ No

NUTRITION EVAULATION

How would you describe your diet currently?	Do you follow someone's nutrition advice? □ Yes □ No If yes, whose?
Are you on a special diet or nutrition plan?	
Do you feel that you are trying to eat healthy? □ Yes □ No	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?
Do you eat breakfast? □ Yes □ No If yes, what?	How often do you eat breakfast?
Number of meals per day:	Number of Snacks per day:
Typically what do you eat for meals and snacks?	
Vegetable intake (please circle) < 10% 20-40% 41-60% >60%	
Do you eat bread or rolls with your meals? If yes, do you use butter/margarine?	Do you drink with meals? If yes, what?
Do you eat red meat? How often?	Do you use dairy? How much?
Do you eat starches (bread, potatoes, white rice, pasta)?	How much (a little, a moderate amount or a lot)?
Do you eat chips?	With meals or for snacks, or both?
Do you drink "energy drinks"? What kind?	How often and when?
Do you drink sweet tea or sugary drinks?	Do you use "high fructose corn syrup" or Agave nector?
Food Allergies:	Food Dislikes
Food(s) you crave	Any specific time of day/month you have craving?
Do you awaken during the night hungry?	If yes, what do you do?
Is it financially or logistically feasible for you to buy most of you food at a store like Whole Foods and to prepare it yourself?	Even prepare it to take with you?

	Yes	No		Yes	No
Partner or spouse overweight? By how many lbs _____			I use artificial sweeteners. What kind? _____		
I overeat.			I plan my meals.		
I eat out daily.			I shop for foods.		
I eat out _____ times/week.			I cook my meals.		
I eat "fast foods" daily.			I use a grocery list for shopping		
I eat "fast foods" _____/week.			I feel full after meals.		
I eat when I'm stressed or sad.			I eat dessert _____ times/week.		
I eat fruit _____times/week			I binge eat at times.		

What non-alcoholic beverages do you drink on a regular basis?

- ☐ Soda (please circle) Diet Regular How much? _____
- ☐ Coffee (please circle) Decaf Regular How much? _____
- ☐ Milk (please circle) Whole 1% 2% Skim Soy Almond How much? _____
- ☐ Tea What kind? _____ How much? _____
- ☐ Fruit Juice What kind? _____ How much? _____

What types of oils do you consume?

☐ Butter	☐ Peanut Oil	☐ Corn Oil	☐ Crisco
☐ Margarine	☐ Flaxseed Oil	☐ Vegetable Oil	☐ Mayonnaise
☐ Olive Oil	☐ Sesame Oil	☐ Canola Oil	☐ Other _____
☐ Coconut Oil	☐ Soybean Oil	☐ Sun/Safflower Oil	

Describe a typical day.

Breakfast	Lunch	Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

Snacks	Snacks
_____	_____
_____	_____
_____	_____
_____	_____
Time eaten: _____	Time eaten: _____
Where: _____	Where: _____

If weight loss is a goal for you, please answer the following questions.	
Goal Weight:	In what time frame would you like to be at your goal weight:
Highest weight (non-pregnant) and when:	Weight one year ago:
Main reason for your decision to lose weight	
When do you begin gaining excess weight? (Give reasons, if know):	

Previous Diets followed	Approximate date & results of weight loss

Additional Information

How motivated are you to achieve your goals? □ Somewhat determined □ Determined □ Very determined □ "Failure is not an option"
Do you give permission to discuss medical status with spouse or significant other? □ Yes □ No If yes, please sign _____
Is there any other information that you would like us to know?