



## Soaring Crane Natural Health Center

209 W Cedar Ave. Palmer, AK 99645. 907.745.3999. soaringcraneclinic.com

### Health History Questionnaire

Successful health care and preventive medicine are made possible by the physician having a thorough understanding of the patient: physically, mentally and emotionally. Please complete this questionnaire as completely as possible. Print all information and mark anything you don't understand with a question mark. Feel free to ask questions in your visit. This is a useful tool for you and for your physician.

Are you currently receiving health care?      Y      N

If yes, from whom? \_\_\_\_\_

\_\_\_\_\_

If no, where did you last receive medical or health care? \_\_\_\_\_

What was the reason? \_\_\_\_\_

What are your most important health problems? List as many as you can in order of importance.

1) \_\_\_\_\_ 4) \_\_\_\_\_

2) \_\_\_\_\_ 5) \_\_\_\_\_

3) \_\_\_\_\_ 6) \_\_\_\_\_

How does your condition affect you?

\_\_\_\_\_

What are your expectations of the physician?

\_\_\_\_\_

What is your definition of health?

\_\_\_\_\_

What do you feel needs to happen for you to be healthy?

\_\_\_\_\_



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How much change are you willing to make at this time for improving your health?

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What support do you have in making lifestyle changes?

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## Family History

Mark with a ✓	FATHER	MOTHER	BROTHER	SISTER	SPOUSE	CHILD
Age (if living)						
Health (G = good. P = poor)						
Age at death (if deceased)						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma/Hayfever/Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Alcoholism						
Cause of death(if deceased)						



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For all the following sections:

**Y** = A condition you have now **N** = Never had **P** = A condition you have had before

### Childhood Illnesses

Scarlet Fever	Y	N	Diphtheria	Y	N	Rheumatic Fever	Y	N
Mumps	Y	N	Measles	Y	N	German Measles	Y	N

### Hospitalizations and Surgeries

What hospitalizations and surgeries have you had?

\_\_\_\_\_ Year \_\_\_\_\_ Year \_\_\_\_\_  
\_\_\_\_\_ Year \_\_\_\_\_ Year \_\_\_\_\_

### X-Rays and Special Studies

X-rays, CAT scans, or other studies you have had:

\_\_\_\_\_  
\_\_\_\_\_  
Electrocardiogram: Y N Electroencephalogram: Y N

### Immunizations:

Polio:	Y	N	Pertussis:	Y	N	Tetanus:	Y	N
Diphtheria	Y	N	Measles, Mumps, Rubella	Y	N	Other	_____	

### Allergies:

Are you hypersensitive or allergic to...

Drug? \_\_\_\_\_

Food? \_\_\_\_\_

Environmental? \_\_\_\_\_

### Current Medications

Do you take or use?

Laxatives	Y	N	Pain Relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Appetite suppressants	Y	N	Antibiotics	Y	N
Tranquilizers	Y	N	Thyroid Meds	Y	N	Sleeping Pills	Y	N

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking (feel free to attach a list if needed).

1) \_\_\_\_\_ 4) \_\_\_\_\_  
2) \_\_\_\_\_ 5) \_\_\_\_\_  
3) \_\_\_\_\_ 6) \_\_\_\_\_



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## Typical Food Intake

Breakfast: \_\_\_\_\_  
 Lunch: \_\_\_\_\_  
 Dinner: \_\_\_\_\_  
 Snacks: \_\_\_\_\_  
 Beverages: \_\_\_\_\_

## Habits:

Main interests and hobbies? \_\_\_\_\_

Do you exercise?	Y	N		
Type of exercise? _____			Frequency? _____	
Average 6-8 hours sleep?	Y	N	Enjoy your work?	Y N
Sleep well?	Y	N	Take vacations?	Y N
Awaken rested?	Y	N	Spend time outside?	Y N
Have a supportive relationship?	Y	N	Watch television?	Y N
Any physical, emotional, mental abuse?	Y	P N	How many hours a day? _____	
Any major trauma?	Y	P N	Read?	Y N
			How many hours a day? _____	
Eat three meals a day?	Y	N	Use alcoholic beverages?	Y P N
Eat out often?	Y	N	Treated for alcoholism?	Y P N
Do you go on diets often?	Y	N	Use tobacco?	Y P N
Drink coffee?	Y	P N	how many years? _____	
Drink black or green tea?	Y	P N	how many packs per day? _____	
Drink cola or other sodas?	Y	P N	Use Recreational drugs	Y P N
Eat refined sugar?	Y	P N		
Add salt?	Y	P N	Spiritual Practice?	Y N
Ever had an eating disorder?	Y	N	If so, type? _____	

## General

Weight \_\_\_\_\_ lbs Weight 1 year ago \_\_\_\_\_ lbs Maximum wt \_\_\_\_\_ lbs When? \_\_\_\_\_  
 Height \_\_\_\_\_

When during the day is your energy the best? \_\_\_\_\_ worst? \_\_\_\_\_



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## Review of Systems

For the Following, Please Circle

**Y = a condition you have now N = never P = a condition you have had in the past**

### Mental/Emotional

Treated for emotional problems?	Y P N	Depression?	Y P N
Mood swings?	Y P N	Anxiety or nervousness?	Y P N
Considered/Attempted suicide?	Y P N	Tension?	Y P N
Poor concentration?	Y P N	Memory problems?	Y P N

### Endocrine

Hypothyroid?	Y P N	Heat or cold intolerance?	Y P N
Hypoglycemia?	Y P N	Diabetes?	Y P N
Excessive thirst?	Y P N	Excessive Hunger?	Y P N
Fatigue?	Y P N	Seasonal depression?	Y P N

### Immune

Do you get vaccinations?	Y P N	Reactions to vaccinations?	Y P N
Chronic fatigue syndrome?	Y P N	Chronic infections?	Y P N
Chronically swollen glands?	Y P N	Slow wound healing?	Y P N

### Neurologic

Seizures?	Y P N	Paralysis?	Y P N
Muscle weakness?	Y P N	Numbness or tingling?	Y P N
Loss of memory?	Y P N	Easily stressed?	Y P N
Vertigo or dizziness?	Y P N	Loss of balance?	Y P N

### Skin

Rashes?	Y P N	Eczema, Hives?	Y P N
Acne, Boils?	Y P N	Itching?	Y P N
Color change?	Y P N	Perpetual Hair Loss?	Y P N
Lumps?	Y P N	Night Sweats?	Y P N

### Head

Headaches?	Y P N	Head Injury?	Y P N
Migraines?	Y P N	Jaw/TMJ problems?	Y P N

### Eyes

Spots in eyes?	Y P N	Cataracts?	Y P N
Impaired vision?	Y P N	Glasses or contacts?	Y P N
Blurriness?	Y P N	Eye pain/strain?	Y P N



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Color blindness?	Y P N	Tearing or dryness?	Y P N
Double vision?	Y P N	Glaucoma?	Y P N

### Ears

Impaired hearing?	Y P N	ringing?	Y P N
Earaches?	Y P N	Dizziness?	Y P N

### Nose

Frequent colds?	Y P N	Nose bleeds?	Y P N
Stiffness or drippy nose?	Y P N	Hayfever?	Y P N
Sinus problems?	Y P N	Loss of smell?	Y P N

### Mouth and Throat

Frequent sore throat?	Y P N	Copious saliva?	Y P N
Teeth grinding?	Y P N	Sore tongue/lips?	Y P N
Gum problems?	Y P N	Hoarseness?	Y P N
Dental cavities?	Y P N	Jaw clicks?	Y P N

### Neck

Lumps?	Y P N	Swollen glands?	Y P N
Goiter?	Y P N	Pain or stiffness?	Y P N

### Respiratory

Cough?	Y P N	Sputum?	Y P N
Spitting up blood?	Y P N	Wheezing?	Y P N
Asthma?	Y P N	Bronchitis?	Y P N
Pneumonia?	Y P N	Pleurisy?	Y P N
Emphysema?	Y P N	Difficulty breathing?	Y P N
Pain on breathing?	Y P N	Shortness of breath?	Y P N
Tuberculosis?	Y P N	“lying down?”	Y P N

### Cardiovascular

Heart disease?	Y P N	Angina?	Y P N
High/Low Blood Pressure?	Y P N	Murmurs?	Y P N
Blood Clots?	Y P N	Fainting?	Y P N
Phlebitis?	Y P N	Palpitations/Fluttering?	Y P N
Rheumatic fever?	Y P N	Chest Pain?	Y P N
Swelling in ankles?	Y P N		



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## Gastrointestinal

Trouble swallowing?	Y P N	Heartburn?	Y P N
Change in thirst?	Y P N	Change in appetite?	Y P N
Nausea?	Y P N	Vomiting?	Y P N
Vomiting blood?	Y P N	Bowel movements: How often? _____	
Blood in stool?	Y P N	Is this a change? _____	
Pain or cramps?	Y P N	Constipation?	Y P N
Belching or passing gas?	Y P N	Diarrhea?	Y P N
Black Stools?	Y P N	Gall Bladder disease?	Y P N
Jaundice (yellow skin)?	Y P N	Ulcer?	Y P N
Liver Disease?	Y P N	Hemorrhoids?	Y P N

## Urinary

Pain on urination?	Y P N	Increased frequency?	Y P N
Frequency at night?	Y P N	Inability to hold urine?	Y P N
Frequent urination?	Y P N	Kidney stones?	Y P N

## Male Reproduction

Hernias?	Y P N	Testicular masses?	Y P N
Testicular Pain?	Y P N	Prostate disease?	Y P N
Venereal disease?	Y P N	Discharge or sores?	Y P N
Are you sexually active?	Y N	Chlamydia?	Y P N
Impotence?	Y P N	Condyloma?	Y P N
Premature ejaculation?	Y P N	Herpes?	Y P N
Birth control? Type? _____		Syphilis?	Y P N
Fertility difficulties?	Y P N	Sexual orientation: _____	

## Female Reproduction/Breasts

Age of first menses? _____		Are cycles regular?	Y N
Age of last menses? _____		Bleeding between cycles?	Y P N
Length of cycle? _____ days		Pain during intercourse?	Y P N
Duration of menses? _____ days		Clotting?	Y P N
Painful menses?	Y P N	Discharge?	Y P N
Heavy or excessive flow?	Y P N	Birth Control?	Y P N
PMS?	Y P N	What type? _____	
If yes, what are your symptoms? _____		Difficulty conceiving?	Y P N
_____		Number of pregnancies? _____	
Endometriosis?	Y P N	Number of live births? _____	
Ovarian cysts?	Y P N	Number of miscarriages? _____	
Cervical dysplasia?	Y P N	Number of abortions? _____	



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Sexual difficulties?	Y P N	Menopausal symptoms?	Y P N
Abnormal pap?	Y P N	Chlamydia?	Y P N
Gonorrhea?	Y P N	Condyloma?	Y P N
Herpes?	Y P N	Syphilis?	Y P N
Are you sexually active?	Y N	Sexual orientation?	_____
Do you do breast self exams?	Y P N	Breast lumps?	Y P N
Breast pain/tenderness?	Y P N	Nipple discharge?	Y P N

### Musculoskeletal

Joint pain or stiffness?	Y P N	Arthritis?	Y P N
Broken bones?	Y P N	Weakness?	Y P N
Muscle spasms or cramps?	Y P N	Sciatica?	Y P N

### Blood/Peripheral Vascular

Easy bleeding or bruising?	Y P N	Anemia?	Y P N
Deep leg pain?	Y P N	Cold hands/feet?	Y P N
Varicose veins?	Y P N	Thrombophlebitis?	Y P N

Is there anything else you would like us to know about your health?

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Thank you! We are honored to witness your journey toward optimal health and wellness!  
- the doctors at Soaring Crane Natural Health Center