



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 only possible when the physician has a complete understanding of the patient, physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and mark anything you don't understand with a question mark.

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) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

How does your condition affect you?

What are you 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?

What support do you have in making lifestyle changes?

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...

Drugs? _____

Foods? _____

Environmentals? _____

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.

1) _____ 2) _____
 3) _____ 4) _____
 5) _____ 6) _____



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Typical Food Intake

Breakfast: _____
 Lunch: _____
 Dinner: _____
 Snacks: _____
 Beverages: _____

Habits:

Main interests and hobbies? _____

Do you exercise?	Y	N			
What kind?	_____		How often?	_____	
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
Have a history of abuse?	Y	N	How many hours?	_____	
Any major trauma?	Y	P N	Read?	Y	N
Use recreational drugs?	Y	P N	How many hours?	_____	
Treated for drug dependence?	Y	P N	Use alcoholic beverages?	Y	P N
Do you eat three meals a day?	Y	N	Treated for alcoholism?	Y	P N
Do you eat out often?	Y	N	Do you use tobacco?	Y	P N
Do you go on diets often?	Y	N	how many years?	_____	
Do you drink coffee?	Y	P N	how many packs per day?	_____	
Do you drink black or green tea?	Y	P N			
Do you drink cola or other sodas?	Y	P N			
Do you eat refined sugar?	Y	P N			
Do you add salt?	Y	P N			
Do you have a religious or spiritual practice?	Y	N	If yes, what?	_____	

General

Weight? _____ lbs Weight 1 year ago _____ lbs Maximum wt ? _____ lbs When? _____
 Height ? _____
 When during the day is your energy the best? _____ worst? _____

Review of Systems

For the Following, Please Circle

Y = a condition you have now N = never had P = a condition you have had before

Mental/Emotional

Treated for emotional problems?	Y	P	N	Depression?	Y	P	N
Mood swings?	Y	P	N	Anxiety or nervousness?	Y	P	N



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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

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
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



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Nose

Frequent colds?	Y P N	Nose bleeds?	Y P N
Stuffiness?	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		

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



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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		

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
Endometriosis?	Y P N	Number of pregnancies? _____	
Ovarian cysts?	Y P N	Number of live births? _____	
Cervical dysplasia?	Y P N	Number of miscarriages? _____	
Sexual difficulties?	Y P N	Number of abortions? _____	
Abnormal pap?	Y P N]Menopausal symptoms?	Y P N
Gonorrhea?	Y P N	Chlamydia?	Y P N
Herpes?	Y P N	Condyloma?	Y P N
Are you sexually active?	Y N	Syphilis?	Y P N
Do you do breast self exams?	Y P N	Sexual orientation? _____	
Breast pain/tenderness?	Y P N	Breast lumps?	Y P N
		Nipple discharge?	Y P N



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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 we should know about your health?

Welcome? We're glad to serve you! If you have any questions, please ask!