



Health History Follow-up Questionnaire

(F)

Today's Date: _____

Name		Date of Birth	
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Current Status **Height:** _____ **Weight:** _____

What symptoms or conditions are you seeking help with?	Clinician's Notes
If this is a follow-up visit for your problem(s), would you say you're doing better, worse, or about the same as before?	
Have you undergone any testing elsewhere? (please note)	
Have you had any treatments elsewhere? (please note)	
Have you received any new diagnoses? (please note)	
What medications, herbs and supplements are you currently taking?	
Have you had any problems or side-effects from any of the above?	
Do you have any new drug allergies? (please note)	

(TURN OVER)

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Please note any other changes to your health since you were last seen here.	Clinician's Notes
Please note any important changes to your family, job, income, good habits or bad habits since you were last seen here.	
How would you rate your current stress level on a scale of 0-10?	

When was your last menstrual period?		
Was it normal?		

Review of Systems: Please check any symptoms you have been having recently

<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Vision changes	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	Fatigue or weakness
<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	Neck or back pain	<input type="checkbox"/>	Shaking or tremor
<input type="checkbox"/>	Nose congestion	<input type="checkbox"/>	Fever or chills	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Trouble breathing	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	Anxiety or easily startled
<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Sweats	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	Irritable mood
<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	Sexual dysfunction
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	Easy bruising
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Brittle nails	<input type="checkbox"/>	Rashes
<input type="checkbox"/>	Bloating	<input type="checkbox"/>	Excess body hair	<input type="checkbox"/>	Dry skin
<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	Menstrual irregularities	<input type="checkbox"/>	Acne
<input type="checkbox"/>	Urinary disturbances	<input type="checkbox"/>	Heavy bleeding	<input type="checkbox"/>	New moles

Please sign		Date	
Reviewed by		Date	