WHOLE FOODS MARKET®
MEDICAL + WELLNESS CENTER

Medical History Questionnaire
Established Patients

Patient Name: _____ Date of Birth: _____ Today's Date: _____

CONCERNS THAT YOU WOULD LIKE TO DISCUSS TODAY:

Any **NEW** concerns you would like addressed at your visit? ☐Yes ☐No
If YES, please explain, _____
_____

If you are experiencing pain, on a scale from 1-10, circle your current level of pain (1 = almost no pain and 10 = the most intense pain imaginable): 1 2 3 4 5 6 7 8 9 10

Have you had any **NEW** Diagnoses since your last visit? ☐Yes ☐No
Diagnosis:_____ Date:_____
Diagnosis:_____ Date:_____

Have you started taking any **NEW** medications since your last visit? ☐Yes ☐No
Medication:_____ Dose:_____
Medication:_____ Dose:_____

Have you had any **NEW** surgeries since your last visit? ☐Yes ☐No
Surgery:_____ Date:_____
Surgery:_____ Date:_____

Have you had any **NEW** hospitalization since your last visit? ☐Yes ☐No
Reason:_____ Date:_____
Reason:_____ Date:_____

Have you had any **NEW** allergies or adverse reactions to medications in the last year? ☐Yes ☐No
If YES, please explain, _____

FAMILY HISTORY: *(Please indicate health of ALL immediate family- **biological** parents and **full** siblings only)*
Has any member of your family been diagnosed with any **NEW** conditions or surgeries?

Mother (Living / Deceased) ☐Yes ☐No ☐N/A If Yes, please describe_____
Father (Living / Deceased) ☐Yes ☐No ☐N/A If Yes, please describe_____
Sister 1 (Living / Deceased) ☐Yes ☐No ☐N/A If Yes, please describe_____
Sister 2 (Living / Deceased) ☐Yes ☐No ☐N/A If Yes, please describe_____
Sister 3 (Living / Deceased) ☐Yes ☐No ☐N/A If Yes, please describe_____
Brother 1 (Living / Deceased) ☐Yes ☐No ☐N/A If Yes, please describe_____
Brother 2 (Living / Deceased) ☐Yes ☐No ☐N/A If Yes, please describe_____
Brother 3 (Living / Deceased) ☐Yes ☐No ☐N/A If Yes, please describe_____
Other: _____

MENSTRUAL / PREGNANCY / BIRTH HISTORY: (female patients only)

Menstrual Cycle:

Date of last menstrual period: _____ Age at which you had your first menstrual cycle: _____

Check which box represents the regularity of your menstrual cycle and then write the length of your cycle below:

☐ Regular cycle ☐ Moderately irregular cycle ☐ Severely irregular cycle ☐ No cycle

Number of days from the first day of your period until the first day of your next period: _____

Duration of period (average amount of days that your period lasts): _____

Check the box that best describes your menstrual flow (average amount of bleeding during your period):

☐ Scant bleeding ☐ Light bleeding ☐ Moderate bleeding ☐ Heavy bleeding

Check all of the boxes below that describe your periods:

☐ No problems ☐ Moderate cramps ☐ Severe cramps ☐ Bloating ☐ Mood swings (PMS)

☐ Other problems _____

Contraception (Birth Control):

Check all the boxes below that represent your current forms of contraception (birth control):

☐ None ☐ Abstinence ☐ Condoms, male ☐ Condoms, female ☐ Contraceptive implant

☐ Spermicide ☐ Depo-Provera ☐ Diaphragm ☐ Hysterectomy ☐ Intrauterine device

☐ NuvaRing ☐ Morning after pill ☐ Oral contraceptives ☐ Rhythm Method ☐ Contraceptive sponge

☐ Withdrawal ☐ Tubal ligation ☐ Vasectomy, partner

Pap Smears:

Approximate date of last pap smear: _____ ☐ Normal ☐ Abnormal

Pregnancies:

Current pregnancy status: ☐ Not pregnant ☐ Pregnant ☐ Positive Home Pregnancy Test ☐ Pregnancy possible

Problems getting pregnant: ☐ Yes ☐ No

Total number of all pregnancies (gravida): _____

Problems during pregnancy: ☐ Yes ☐ No

Check all the boxes below that represent any problems that you have had with past pregnancies:

☐ Abuse ☐ Depression ☐ Eclampsia (convulsions) ☐ Ectopic pregnancy

☐ Excess amniotic fluid ☐ Excessive bleeding ☐ Excessive weight gain ☐ Excessive vomiting

☐ Fetal distress ☐ Gestational diabetes ☐ Inadequate weight gain ☐ Inadequate prenatal care

☐ Infection (amnionitis) ☐ Low amniotic fluid ☐ Placenta previa (abnormal attachment of placenta)

☐ Pre-eclampsia (high blood pressure) ☐ Premature rupture of membranes ☐ Premature labor

☐ Retained placenta ☐ Stillbirth ☐ Other: _____

Total number of deliveries (para): ☐ Vaginal delivery # _____ ☐ C-Section # _____

☐ Term delivery # _____ ☐ Pre-term # _____

Complications during delivery: ☐ None ☐ Yes, # _____

Check all the boxes below that represent any problems that you have had during past deliveries:

☐ Abnormal placenta ☐ Failed forceps delivery ☐ Failed vacuum extraction ☐ Fetal distress

☐ Knot of umbilical cord ☐ Maternal bleeding ☐ Two-vessel umbilical cord ☐ Umbilical cord around neck

☐ C-section complications ☐ Other:_____

Total number of terminations (aborta): ☐ Spontaneous (miscarriages) # _____ ☐ Elective # _____

Total number of multiple gestation pregnancies (twins, triplets, etc.):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ >4

Completed the Gardasil series (vaccination for HPV): ☐ Yes ☐ No ☐ Unsure

Name: _____ **Date of Birth:** _____

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Please place a check mark in the box for Normal if you do not have any of the symptoms or problems listed in the corresponding box. Your doctor will discuss any positive responses with you.

General: ☐**Normal**

- ❑ Appetite Loss
- ❑ Chills
- ❑ Dietary Changes
- ❑ Fatigue
- ❑ Fever
- ❑ Night Sweats
- ❑ Shakiness
- ❑ Weight Gain
- ❑ Weight Loss

Skin: ☐**Normal**

- ❑ Bruising
- ❑ Change in Wart/Mole
- ❑ Coarse Hair
- ❑ Coarse Skin
- ❑ Cold Skin
- ❑ Cracked Lips
- ❑ Dryness
- ❑ Excessive Sweating
- ❑ Hair Growth
- ❑ Hair Loss
- ❑ Hives
- ❑ Itching
- ❑ Nail Changes
- ❑ New Lesions
- ❑ Rash
- ❑ Skin Color Changes
- ❑ Ulcer

HEENT: ☐**Normal**

- ❑ Headache
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Excessive Tearing
- ❑ Eye Pain
- ❑ Eye Redness
- ❑ Glaucoma
- ❑ Visual Loss
- ❑ Wear Glasses/Contacts lenses
- ❑ Hearing Loss
- ❑ Ear Discharge
- ❑ Ear Infection
- ❑ Ear Pain
- ❑ Ringing in the Ears
- ❑ Spinning Sensation
- ❑ Runny Nose
- ❑ Nose Bleeds
- ❑ Frequent Colds
- ❑ Nasal Congestion
- ❑ Sneezing
- ❑ Seasonal Allergies
- ❑ Sleep Apnea
- ❑ Sinus Pain
- ❑ Snoring
- ❑ Mouth or Lip Sores
- ❑ Bleeding Gums
- ❑ Hoarseness
- ❑ Sore Throat
- ❑ Dry Mouth
- ❑ Decreased Sense of Smell
- ❑ Facial Numbness/Tingling
- ❑ Decreased Sense of Taste
- ❑ Choking Sensation
- ❑ Difficulty Chewing

Neck: ☐**Normal**

- ❑ Neck Pain
- ❑ Neck Stiffness
- ❑ Neck Swelling
- ❑ Swollen Glands

Respiratory: ☐**Normal**

- ❑ Cough
- ❑ Coughing up Blood
- ❑ Decreased Exercise Tolerance
- ❑ Difficulty Breathing
- ❑ Shortness of Breath
- ❑ Sputum Production
- ❑ Wheezing

Breast: ☐**Normal**

- ❑ Breast Mass
- ❑ Breast Pain
- ❑ Breast Swelling
- ❑ Nipple Discharge
- ❑ Nipple Pain
- ❑ Recent Breast Size Changes
- ❑ Skin Changes

Cardiovascular: ☐**Normal**

- ❑ Chest Pain
- ❑ Difficulty Breathing While Lying Down
- ❑ Elevated Blood Pressure
- ❑ Fainting / Blacking Out
- ❑ Heart Murmur
- ❑ Heart Stent
- ❑ Irregular Heartbeat
- ❑ Leg Cramps
- ❑ Leg Swelling
- ❑ Night Cramps
- ❑ Rapid Heart Rate
- ❑ Slow Heart Rate

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(Review of Systems Continued)

Gastrointestinal: ☐**Normal**

- ❑ Abdominal Mass
- ❑ Abdominal Pain
- ❑ Abdominal Swelling
- ❑ Belching
- ❑ Black, Tarry Stool
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficulty Swallowing
- ❑ Excessive Gas
- ❑ Food Intolerance
- ❑ Gets Full Quickly at Meals
- ❑ Hemorrhoids
- ❑ Heartburn
- ❑ Incontinence of Stool
- ❑ Indigestion
- ❑ Jaundice
- ❑ Laxative Use
- ❑ Nausea
- ❑ Painful Swallowing
- ❑ Pain with Bowel Movement
- ❑ Rectal Bleeding
- ❑ Vomiting
- ❑ Vomiting Blood

Genitourinary: ☐**Normal**

(Male and Female)

- ❑ Blood in Urine
- ❑ Change in Urinary Stream
- ❑ Flank / Side Pain
- ❑ Hesitancy of Urine Flow
- ❑ Incontinence
- ❑ Painful Urination
- ❑ Urgency
- ❑ Urinary Retention
- ❑ Urinating at Night
- ❑ Urine Leakage

(Male Only)

- ❑ Difficulty with Erection
- ❑ Penile Lesions
- ❑ Testicular Mass
- ❑ Testicular Pain
- ❑ Discharge from the Penis

(Female Only)

- ❑ Absence of Menstruation
- ❑ Difficulty Emptying Bladder
- ❑ Excessive Menstrual Bleeding
- ❑ Excessive Non-Menstrual Bleeding
- ❑ Excessive Urination
- ❑ Menstrual Irregularities
- ❑ Painful Intercourse
- ❑ Painful Menstruation
- ❑ Pelvic Pain
- ❑ Urethral Discharge
- ❑ Vaginal Bleeding
- ❑ Vaginal Discharge
- ❑ Vaginal Dryness
- ❑ Vaginal Fluid
- ❑ Vaginal Itching / Burning

Musculoskeletal: ☐**Normal**

- ❑ Back Pain
- ❑ Decreased Range of Motion
- ❑ Joint Pain
- ❑ Joint Redness
- ❑ Joint Stiffness
- ❑ Joint Swelling
- ❑ Muscle Wasting
- ❑ Muscle Cramps
- ❑ Muscle Pain
- ❑ Muscle Weakness
- ❑ Muscle Swelling

Neurological: ☐**Normal**

- ❑ Decreased Memory
- ❑ Difficulty Speaking
- ❑ Dizziness
- ❑ Easily Distracted
- ❑ Fainting
- ❑ Hyperactivity
- ❑ Incoordination
- ❑ Loss of Consciousness
- ❑ Numbness
- ❑ Seizures
- ❑ Stroke
- ❑ Tremor
- ❑ Trouble Walking
- ❑ Unusual Sensation
- ❑ Unsteadiness
- ❑ Weakness in an Arm or Leg
- ❑ Generalized Weakness
- ❑ Muscle Twitching

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Psychiatric: □**Normal**

- ❑ Anxiety
- ❑ Change in Sleep Pattern
- ❑ Depression
- ❑ Disorientation
- ❑ Early Awakening
- ❑ Easily Irritated
- ❑ Fearful
- ❑ Frequent Crying
- ❑ Hallucinations
- ❑ Hypersomnia
- ❑ Memory Loss
- ❑ Mood Changes
- ❑ Nervousness
- ❑ Panic Attacks
- ❑ Suicidal Thoughts
- ❑ Suicidal Planning
- ❑ Trouble Falling Asleep
- ❑ Personality Changes

Endocrine/Glands: □**Normal**

- ❑ Appetite Changes
- ❑ Cold Intolerance
- ❑ Decreased Sweating
- ❑ Excessive Sweating
- ❑ Excessive Thirst
- ❑ Hair Changes
- ❑ Heat Intolerance
- ❑ Hot Flashes
- ❑ Libido Change
- ❑ Sexual Dysfunction
- ❑ Thyroid Problems

Hematology: □**Normal**

- ❑ Anemia
- ❑ Blood Clots
- ❑ Easy Bruising
- ❑ Easy Bleeding
- ❑ Enlarged Lymph Nodes
- ❑ Gland Problems
- ❑ Painful Lymph Nodes