WHOLE FOODS MARKET®
MEDICAL + WELLNESS CENTER

Welcome Packet- Medical History Questionnaire

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

CONCERNS THAT YOU WOULD LIKE DISCUSSED AT YOUR NEXT VISIT:
Any concerns you would like addressed at your visit? (Answer below for each concern if applicable): _____
_____
Any symptoms you are concerned about? _____
When did symptoms first occur? _____
How often do you experience these symptoms (hourly / daily / weekly)? _____
Describe the severity of the symptoms / pain. _____
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
Are there any other symptoms associated with your problem? _____
_____
What makes the condition better? _____
What makes the condition worse? _____
Do you feel that your condition is work-related (happened while working)? ☐ Yes ☐ No

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PROBLEM LIST/PAST MEDICAL HISTORY: ☐ ***I have no current/past medical problems***
Have you been diagnosed with any of the following (currently or in the past)?

☐ Allergies (Hay Fever)	☐ Chronic Kidney Disease	☐ Headache	☐ Low Thyroid
☐ Anemia	☐ Constipation	☐ Hearing Loss	☐ Memory Loss
☐ Anxiety	☐ COPD	☐ Heart Arrhythmia	☐ Migraine
☐ Arthritis	☐ Crohn's Disease	☐ Heart Attack	☐ Obesity
☐ Asthma	☐ Depression	☐ Heart Failure	☐ Psoriasis
☐ Back Pain	☐ Diabetes	☐ Heartburn / GERD	☐ Sinusitis
☐ Cancer, Breast	☐ Diarrhea	☐ Hemorrhoids	☐ Stomach Ulcers
☐ Cancer, Colon	☐ Eczema	☐ Hepatitis	☐ Stroke
☐ Cancer, Lung	☐ Fibromyalgia	☐ High Blood Pressure	☐ Trouble Sleeping
☐ Cancer, Prostate	☐ Gallstones	☐ High Cholesterol	☐ Ulcerative Colitis
☐ Cardiovascular Dis.	☐ Gout	☐ Kidney Stones	☐ Urinary Tract Infection

☐ Other: _____

ALLERGY HISTORY:
☐ **NKDA (No Known Drug Allergies)** ☐ **No Known Food or Contact Allergies**

☐ Acetaminophen	☐ Epinephrine	☐ Latex	☐ Penicillin
☐ Aspirin	☐ Erythromycin	☐ Lidocaine	☐ Sulfur
☐ Codeine	☐ Ibuprofen	☐ Metal	☐ Tetracycline

Other (include foods): _____

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

MEDICATION HISTORY:

☐ I am not currently taking any medications, vitamins, or other supplements

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication / Supplement	Dosage	Name of Medication / Supplement	Dosage

Total number of medications and vitamins / supplements that I take on a regular basis is: _____

PAST SURGICAL HISTORY: ☐ **No past surgeries**

List significant surgeries or injuries:

- ☐ Adenoidectomy (date: _____)
- ☐ Appendectomy (date: _____)
- ☐ Breast Augmentation (date: _____)
- ☐ Cataract Surgery (date: _____)
- ☐ Gallbladder Surgery (date: _____)
- ☐ Hernia Repair (date: _____)
- ☐ Hysterectomy - Abdom. (date: _____)
- ☐ Hysterectomy - Vaginal (date: _____)
- ☐ Knee Surgery - Both (date: _____)
- ☐ Knee Surgery - Left (date: _____)
- ☐ Knee Surgery - Right (date: _____)
- ☐ Laser Eye Surgery (date: _____)
- ☐ Reduced Fracture - Open (date: _____)
- ☐ Shoulder Surgery - Both (date: _____)
- ☐ Shoulder Surgery - Left (date: _____)
- ☐ Shoulder Surgery - Right (date: _____)
- ☐ Spinal Fusion – Low Back (date: _____)
- ☐ Spinal Fusion – Neck (date: _____)
- ☐ Tonsillectomy (date: _____)
- ☐ Total Hip Replaced - Both (date: _____)
- ☐ Total Hip Replaced - Left (date: _____)
- ☐ Total Hip Replaced - Right (date: _____)

Other Surgeries/Injuries *Date(s) or Age*

_____

_____

_____

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions? Circle whether each family member is living or deceased. Then place an "X" under any conditions that they have now or had before they passed away. Circle the "X" if the family member passed away due to that condition. List any other illnesses these family members have had on the line below.

	High Blood Pressure	Heart Disease	Diabetes	Cancer	High Cholesterol
Mother (Living / Deceased)	_____	_____	_____	_____	_____
Father (Living / Deceased)	_____	_____	_____	_____	_____
Sister 1 (Living / Deceased)	_____	_____	_____	_____	_____
Sister 2 (Living / Deceased)	_____	_____	_____	_____	_____
Sister 3 (Living / Deceased)	_____	_____	_____	_____	_____
Brother 1 (Living / Deceased)	_____	_____	_____	_____	_____
Brother 2 (Living / Deceased)	_____	_____	_____	_____	_____
Brother 3 (Living / Deceased)	_____	_____	_____	_____	_____
Additional Family: S / B (L / D)	_____	_____	_____	_____	_____

Other: _____

_____

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

SOCIAL HISTORY:

Energy: On a scale from 1-10, circle what your current energy level is during the day (1 = difficult to move and 10 = bouncing around full of energy):

1 2 3 4 5 6 7 8 9 10

Well-being / Stress: On a scale from 1-10, circle your current stress level (1 = complete and total stress / no well-being and 10 = no stress at all / total well-being):

1 2 3 4 5 6 7 8 9 10

Check any sources of stress present in your life:

☐ None ☐ Financial ☐ Job related ☐ Family ☐ Spouse/Partner ☐ Children
☐ Friends ☐ Social pressures ☐ Health ☐ School ☐ Traffic
☐ Other: _____

Check any hobbies / activities you participate in to help you with stress and provide well-being:

☐ None ☐ Arts and crafts ☐ Fitness ☐ School activities ☐ School sports
☐ Community sports ☐ Cooking / baking ☐ Martial arts ☐ Gymnastics ☐ Vocal music
☐ Instrumental music ☐ Drama ☐ Debate ☐ Religious activities ☐ Community service
☐ Computers ☐ Reading / writing ☐ Dance ☐ Golf ☐ Boating / sailing
☐ TV / movies ☐ Cycling / biking ☐ Running ☐ Hiking / walking ☐ Outdoors activities
☐ Other: _____

Diet / Nutrition:

On a scale from 1-10, circle the number that best describes the overall health of your diet at this time (1 = completely unhealthy / very unhealthy and 10 = totally healthy):

1 2 3 4 5 6 7 8 9 10

Check the box that best describes the variety of foods (nutritional balance) in your diet:

☐ Restricting (inadequate calories) ☐ Poorly-balanced ☐ Moderately-balanced ☐ Well-balanced

Check <u>all</u> of the boxes below that describe your current diet:

☐ Western (American) ☐ American Diabetes Assoc. ☐ Gluten-free ☐ High fiber ☐ High protein
☐ Low calorie ☐ Low carbohydrate ☐ Low cholesterol ☐ Low fat ☐ Low protein
☐ Low sodium ☐ Mediterranean ☐ Paleo ☐ Plant-based ☐ American Heart Assoc.
☐ TLC ☐ Vegan ☐ Vegetarian ☐ Weight loss
☐ Other: _____

Caffeine: Check <u>all</u> of the boxes next to any of the sources of caffeine that you consume regularly and then circle the number of servings per day:

☐ Coffee ☐ Tea ☐ Carbonated beverages ☐ Energy drinks ☐ Guarana drinks ☐ Chocolate
☐ Medicines ☐ Dietary supplements
Other: _____
Servings per day average: 0 <1 1 2 3 4 5 6 7 8 >8

Alcohol: Check <u>all</u> of the boxes that describe your current alcohol use and then circle the number of servings per day:

☐ Never ☐ Occasional ☐ Moderate ☐ Heavy ☐ Recently quit ☐ Quit years ago
☐ Beer ☐ Wine ☐ Cider ☐ Hard liquor ☐ Other
Servings per day average: 0 <1 1 2 3 4 5 6 7 8 >8

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Tobacco: Check all of the boxes that describe your current or past tobacco use and then circle the number of cigarettes per day (if applicable):

☐ Never smoker ☐ Current some days smoker ☐ Current every day smoker

☐ Former smoker (Approximate age started: _____ age stopped: _____)

Cigarettes per day average: 0 <1 1 2 3 4 5 6 7 8 9 10 >10

Number of years smoking: _____ Type of Tobacco (if other than cigarettes): _____

Had a blood test for smoking (cotinine test) in the last 12 months: ☐ Yes ☐ No

Result of the last blood test for smoking (cotinine test): ☐ Positive ☐ Negative

Number of stop-smoking classes completed in the last 12 months: ☐ 0 ☐ 1 ☐ 2

Cravings / Deprivation: Check any sources of cravings, or things that can cause you to feel deprived, if you do not get:

☐ None ☐ Free time ☐ Time for relaxation and rest ☐ Sweet foods

☐ Savory / salty foods ☐ Fatty foods ☐ Carbohydrates ☐ Meats

☐ Dairy ☐ Fast food ☐ Candy ☐ Chips ☐ Breads

☐ Soda / sugary drinks ☐ Caffeine ☐ Alcohol ☐ Tobacco ☐ Drugs

Other: _____

On a scale from 1-10, circle the number that best describes how deprived you feel right now? (1 = you are using every ounce of willpower to maintain your current diet and level of health and 10 = you are eating and doing whatever you want every day):

1 2 3 4 5 6 7 8 9 10

Activity / Exercise: Check the box below that most represents your overall activity level:

☐ Inactive ☐ Light ☐ Moderate ☐ Heavy ☐ Vigorous

Check the boxes below that represent your current activities / ways of getting exercise, then circle the number of times per week and the average amount of time per day that you participate:

☐ None ☐ Walking / hiking ☐ Golf (walk course) ☐ Bowling ☐ Housework ☐ Gardening

☐ Yardwork ☐ Cycling / biking ☐ Running / jogging ☐ Team sports ☐ Racquet sports ☐ Yoga

☐ Martial arts ☐ Aerobic classes ☐ Exercise classes ☐ Pilates ☐ Stretching ☐ Balance

☐ Dance ☐ Resistance training ☐ Rock climbing

Other: _____

Times per week: 1 2 3 4 5 6 7 >7

Average minutes per day: 5-10 10-15 15-20 20-30 30-45 45-60 60-90 90-120 >120

Sleep: On a scale from 1-10, circle the number representing your current quality of sleep (1 = not rested at all and 10 = completely rested):

1 2 3 4 5 6 7 8 9 10

Circle the average number of hours slept per night:

1 2 3 4 5 6 7 8 9 10 >10

Sunlight: Check all of the boxes below that describe your sun exposure most days, then circle the average number of minutes per day that you get quality sunlight exposure (>50% of skin exposed with UV index >3 and <6; usually between the hours of 10am and 2pm):

☐ Minimal ☐ Occasional incidental ☐ Occasional purposeful

☐ Significant / purposeful ☐ Outdoor employment ☐ Outdoor exercise / activities

Minutes of quality sunlight per day: 0 5 10 15 20 30 45 60 90 120 >120

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

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

Menstrual Cycle:

Date of last menstrual period: _____

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 _____

Age at which you had your first menstrual cycle _____

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 # _____

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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

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TREATING PRACTITIONERS / PROVIDERS:

Please list any physicians, other healthcare professionals or "non-traditional" providers that you are currently seeing or have seen in the last 1-2 years (Please include treatment by providers in any of the following disciplines: conventional medicine, osteopathy, acupuncture, chiropractic, naturopathic, homeopathic, physical therapy, etc.):

1. _____
2. _____
3. _____
4. _____
5. _____

HEALTH GOALS:

Please list your top 3 health goals in order of importance (tell us what needs to be achieved for you to feel that you have had a successful and healing experience with us):

1. _____
2. _____
3. _____

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

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

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

(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
- ❑ Tingling

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

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