Whole Health and Nutrition, LLC
Leanne J. Sotir, PhD, RNCP
Natural Health Practitioner/Registered Nutritional Consultant
Phone (781) 987-4947 / Fax (678) 866-9444 / drsotir@wholehealthandnutrition.com

HEALTH HISTORY QUESTIONNAIRE

Please answer these questions to the best of your ability. Being accurate, honest, and detailed will produce the best possible outcome from the consultation.

Date_____ Office Visit ___ Phone Consultation ___ Skype ___

Name_____
Address_____ City_____
State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone_____
E-Mail Address_____
Age ____ DOB ___/___/___ Sex: M ___ F ___ Weight _____
Height _____ Blood Type _____
Marital Status: Single ___ Married ___ Separated ___ Widowed ___
Children Y ____ N___ if yes, how many? _____
Occupation: Current _____ Occupation: Past (only if different) _____
Emergency Contact: _____Relationship_____ Phone: _____

Please explain what has brought you to Whole Health and Nutrition, and what are the main health concerns you would like to address _____
_____
_____
_____
_____
_____

LIFESTYLE
What are your levels of stress? Low ___ Med ___ High ___
Do you exercise regularly? Yes ___ No ___ if yes, how often? _____x per week _____ Minutes per session _____
What type of exercise? _____
Do you get adequate sunshine? Yes ___ No ___
Do you have pets? Yes ___ No ___
Have you tried any alternative modalities such as Acupuncture, Chiropractic, Herbal Therapy, etc? Yes ___ No ___ if yes, please explain _____
_____
_____
_____
Do you currently smoke? Yes ___ No ___ if yes, how much per day? _____
Do you live with a smoker or are you exposed to second hand smoke? Yes ___ No ___Have you ever smoked in the past? Yes ___ No ___if yes, how long? _____
Do you use recreational drugs? Yes ___ No ___ if yes, which ones? _____ How often? _____
Do you travel for work? Yes ___ No ___
Do you travel outside the country? Yes ___ No ___ In the past ___
Have you been vaccinated recently? Yes ___ No ___ if yes, which one? _____
How often do you drink alcohol (Wine, Beer, Liquor)? Never ____ Occasionally ___ Daily ____ How much do you consume? _____
Where do you carry most of your weight? Belly ___ Hips ___ Buttocks ___ Upper Stomach ___

NUTRITION

Have you ever been a vegetarian? Yes ___ No ___ if yes, please explain _____

_____

_____

_____

Do you consume soy products? Yes ___ No ___ if yes, please explain which ones _____

_____

What type of oils do you cook with? _____

Do you eat breakfast on a regular basis? Yes ___ No ___

Do you eat out at restaurants regularly? Yes ___ No ___ On occasion ___

Do you eat fast foods? Yes ___ No ___ if yes, how often: Daily _____ Weekly _____ Monthly _____

Do you eat Sushi (raw fish)? Yes ___ No ___

Are you allergic to any of these foods? Wheat ___ Dairy ___ Corn ___

Soy ___Eggs ___Shellfish ___ Chocolate ___ Gluten ___ Peanuts ___

Food additives/dyes ___ Other _____

Please list any known allergens that are not listed above such as latex, pollen, dust, etc. _____

_____

_____

_____

Do you have any food cravings? Yes ___ No ___ if yes, please explain _____

_____

_____

What are your favorite foods that you consume often? _____

_____

_____

What type of salt do you use? Table salt ___ Sea salt ___

What type of beverages do you consume? Coffee ___ Decaffeinated coffee __ Hot tea ___ Bottled iced tea __

Soda __Diet soda __ Sports drinks ___Vitamin water___ Fruit juice ___ Milk ___

Do you drink water on a daily basis? Yes ___ No ___

What kind of water do you drink? Tap___ Distilled___ Bottled ___ Reverse Osmosis ___ Well ___

Do you consume artificial sweeteners? Yes ___ No ___ if yes, which ones? _____

ENVIRONMENT

Are you bothered by perfume, air fresheners, candles, cigarette smoke, etc? Yes ___ No ___ Sometimes ___

Have you ever been exposed to toxic chemicals? Yes ___ No ___

Do you suffer from Multiple Chemical Sensitivity/Environmental Illness? Yes ___ No ___

Have you ever been tested for Multiple Chemical Sensitivity/Environmental Illness? Yes ___ No ___ if yes, please explain _____

_____

_____

CURRENT MEDICAL HISTORY

Do you currently suffer from any of the following?

Asthma	**Yes ___ No ___**
Cancer	**Yes ___ No ___**
High Cholesterol	**Yes ___ No ___**
High Blood Pressure	**Yes ___ No ___**
Low Blood Pressure	**Yes ___ No ___**
Type 2 Diabetes	**Yes ___ No ___**
Pre-diabetes/Insulin Resistance	**Yes ___ No ___**
Hypoglycemia (low blood sugar levels)	**Yes ___ No ___**
Thyroid Disease	**Yes ___ No ___**
Heart/Vascular Disease	**Yes ___ No ___**
Stroke	**Yes ___ No ___**
Headaches/Migraines	**Yes ___ No ___**

Please list all other medical conditions not listed above _____

_____

Please list any recurring health conditions you suffer from _____

_____

Please list any structural issues such as back, knee, or other joint problems you suffer from _____

_____

_____

BOWEL/DIGESTIVE HEALTH

Do you have a bowel movement every day? Yes ___ No ___ if yes, how often _____X daily

Color of stool: Brown ___ Yellow ___ Grey ___

Consistency of stool: Firm __ Loose ___ Pellets ___

Do you suffer from Gallstones? Yes ___ No ___

Do you suffer from Crohn's Disease? Yes ___ No ___

Do you suffer from Ulcerative Colitis? Yes ___ No ___

Do you suffer from Celiac Disease or Gluten Intolerance? Yes ___ No ___

If you suffer from other digestive issues, please explain: _____

_____

_____

Have you had a Gastric bypass? Yes ___ No ___ Do you have a Lap-band? Yes ___ No ___

	YES	**NO**	**SOMETIMES**
Diarrhea	___	___	___
Constipation	___	___	___
Fatty/oily stools	___	___	___
Undigested food in stools	___	___	___
Foul smelling stools	___	___	___
Mucous in stools	___	___	___
Rectal itching	___	___	___
Bad breath	___	___	___
Belching after meals	___	___	___
Excessive gas and bloating after meals	___	___	___
Heartburn or reflux after meals	___	___	___
Certain foods cause distress	___	___	___
Hemorrhoids	___	___	___

EMOTIONAL HEALTH/OVERALL SENSE OF WELL-BEING

How would you describe your emotional health? _____

_____

	YES	NO	SOMETIMES
Depression	___	___	___
Worry, anxiety, nervousness	___	___	___
Obsessive Compulsive Disorder (OCD)	___	___	___
Panic disorder	___	___	___
Easily upset, cry easily	___	___	___
Bouts of irritability	___	___	___
Feelings of hopelessness	___	___	___
Low self-esteem, lack of confidence	___	___	___
Difficulty focusing	___	___	___
Difficulty getting to sleep and staying asleep	___	___	___
Emotional eater	___	___	___

SKIN HEALTH	YES	NO	SOMETIMES
Dry Skin	___	___	___
Itchy Skin	___	___	___
Acne	___	___	___
Eczema	___	___	___
Dermatitis	___	___	___
Psoriasis	___	___	___
Rosacea	___	___	___
Dandruff	___	___	___
Hives	___	___	___

DENTAL HEALTH

Do you have any root canals? Yes ___ No ___ if yes, how many? _____

Do you have amalgams (silver fillings)? Yes ___ No ___ if yes, how many _____

Do you have crowns? Yes ___ No ___ if yes, how many? _____

Do you have bridges? Yes ___ No ___ if yes, how many? _____

Do you currently have any infected teeth that need attention? Yes ___ No ___

Have you ever had a tooth infection in the past? Yes ___ No ___if yes, please explain _____

_____

_____

Do you have gingivitis or periodontal disease? Yes ___ No ___

Do you have receding gums? Yes ___ No ___

Do your gums bleed when you brush your teeth? Yes ___ No ___

Do you suffer from TMJ syndrome? Yes ___ No ___ Past ___

WOMEN'S HEALTH

Do you use birth control pills? Yes ___ No ___Past ___if yes or in the past, how long? _____
Do you use hormone replacement therapy? Yes ___ No ___ Past ___ if yes or in the past how long? _____
Do you have menstrual irregularities or PMS? Yes ___ No ___ if yes, please explain _____
_____
_____
_____
Are you currently menstruating? Yes ___ No ___
Have you ever had an abnormal Pap smear? Yes ___ No ___ if yes, please explain _____
_____
_____
_____

Did you suffer from postpartum depression after giving birth (if applicable)? Yes ___ No ___
Endometriosis Yes ___ No ___
Uterine Fibroids Yes ___ No ___
Fibrocystic Breasts Yes ___ No ___
Ovarian Cysts Yes ___ No ___

Do you have a problem with infertility? Yes ___ No ___ Past ___ if yes or in the past, please explain
_____
_____
Do you have breast implants? Yes ___ No ___if yes, how long? _____
Do you wear a wire bra? Yes ___ No ___
Have you experienced menopause? Yes ___ No ___ if yes, at what age _____ Please explain your experience
_____
_____

MALE HEALTH

Do you currently suffer from prostate problems? Yes ___ No ___ if yes, please explain _____
_____
_____
What are your current PSA levels? _____

CHILDHOOD HEALTH

Were you a healthy child? Yes ___ No ___
Please list all conditions or diseases you suffered as a child if any, even if they may seem insignificant:

CONDITION/DISEASE	AGE	MEDICATIONS TAKEN
_____	____	_____
_____	____	_____

TRAUMA/ACCIDENTS

Please list any trauma or accident from which you have suffered from, either currently or in the past (including childhood events) that you feel may affect your health today.

TRAUMA/ACCIDENT	DATE/AGE
_____	_____

PAST MEDICAL HISTORY

Please list any past medical conditions/diseases you have recovered from.

CONDITION/DISEASE	DATE/AGE
_____	_____
_____	_____

SURGERIES

Please check off any organs that have been surgically removed:

		DATE
Adenoids	___	_____
Tonsils	___	_____
Full Hysterectomy	___	_____
Uterus	___	_____
Ovary/Ovaries	___	_____
Thyroid Gland	___	_____
Thymus Gland	___	_____
Gall Bladder	___	_____
Appendix	___	_____
Kidney	___	_____
Part of Colon	___	_____

Please list any other surgical procedures you have had (include date if possible) _____

_____

FAMILY'S MEDICAL HISTORY

Do any close family relatives suffer from any of these conditions/diseases? (please include parents, siblings, children, and spouse)

	Relative
□Osteoporosis	_____
□Type I Diabetes	_____
□Type II Diabetes	_____
□Pre-diabetes/Insulin Resistance	_____
□Hypoglycemia	_____
□Stroke	_____
□High Blood Pressure	_____
□Heart Disease	_____
□Atherosclerosis	_____
□Thyroid Disease	_____
□Cancer	_____
□Gall bladder Disease	_____
□Kidney Disease	_____
□Liver Disease	_____
□Celiac Disease/Gluten Intolerance	_____
□Mental Illness	_____
□Depression	_____
□Multiple Sclerosis	_____
□ADD/ADHD	_____
□Alcoholism	_____
□Asthma	_____
□Alzheimer's Disease	_____

□Other, Please explain: _____

_____

_____

Is your father still living? Yes; his age ___ No; age at time of death ___ Cause of death _____

_____

Is your mother still living? Yes; her age ___ No; age at time of death ___ Cause of death _____

_____

CURRENT PRESCRIPTION MEDICATION

Please check off any prescriptions medications you are currently taking.

Antianxiety ___
Antidepressants ___
Psychotropic meds ___
Anticoagulants (Warfarin or any other blood thinners) ___
Digoxin ___
Aspirin ___
Oral contraceptives ___
Hormone replacement therapy ___
Anti-seizure meds ___
Cholesterol meds ___
Oral diabetes meds ___
Blood pressure meds ___
Thyroid meds ___

Please list any other prescription drugs that you are currently taking, including all over the counter medication.

DRUG NAME	CONDITION/DISEASE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SUPPLEMENTS

Please list all supplements you are currently taking daily, this includes vitamins, minerals, essential fatty acids (flaxseed or fish oil), herbs, amino acids, etc. Be sure to list brand names, potency (mgs, mcgs, or units). Please bring these with you to your scheduled appointment.

SUPPLEMENT NAME & BRAND	DAILY DOSAGE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____