INTEGRATED MEDICAL GROUP

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PATIENT VITAL INTAKE [HQ] HEALTH QUESTIONAIRE

Patient Name _____ **Home Phone** _____ **Work Phone** _____

Birthdate _____/_____/_____ **Age** _____ **Height** _____ **Weight** _____ **Cell Phone** _____

Complaints: **How long has it been occurring?** **Treatment/Palliative action (What makes it feel better)?**

_____

_____

_____

Please list all surgeries, traumas, medications, and allergies. Give dates, age of occurrences, or years as best as you can remember.

_____

_____

_____

Family Medical History

O Obesity O Stroke O Seizures O Other Diseases / Cancer (explain below)
O Diabetes O Heart Disease O High Blood Pressure

Your Habits

O Cigarettes O Alcohol ***Drinks Per Week:*** _____
O Marijuana ***Frequency*:** O *Occasionally* O *Often*
O Unprescribed Drugs ***Please explain:*** _____
O Coffee O Tea O Carbonated Beverages ***Cups/Glasses/Cans per day:*** _____
O Bitter Chocolate O Sweet Chocolate
O Sugar O Artificial Sweetener O Salt

Please explain any cravings or any other items you feel are important that we know:

_____

General Issues

O Poor Appetite O Heavy Appetite O Poor Sleep O Heavy Sleep
O Insomnia O Fatigue O Tremors O Vertigo
O Cold Hands O Cold Feet O Cold Back O Cold Abdomen
O Fevers O Chills O Night Sweats O Sweat Easily
O Cravings O Localized Weakness O Poor Coordination O Changes in Appetite
O Sudden Energy Drops ***(Time?)*** _____ O Peculiar Tastes/Smells ***(explain?)*** _____
O Strong Thirsts ***(cold/hot drinks)*** _____ O Bleed / Bruise Easily ***(where?)*** _____

_____

_____

Skin / Hair

O Rashes O Ulcerations O Hives O Itching
O Eczema O Pimples O Dandruff O Loss of Hair
O Change in Hair/Skin Texture O Purpua O Other hair/skin issues ***(explain below)***

_____

_____

Head / Eyes / Ears / Nose / Throat

O Dizziness O Concussions O Migraines O Wear Corrective Lenses
O Eye Strain O Eye Pain O Poor Vision O Night Blindness
O Color Blindness O Cataracts O Blurry Vision O Earaches
O Ringing in Ears O Poor Hearing O Nose Bleeds O Sinus Problems
O Mucus O Dry Throat O Dry Mouth O Copious Saliva
O Teeth Problems O Jaw Clicks O Grinding Teeth O Facial Pain
O Gum Problems O Spots in Eyes O Recurrent Sore Throats ***(how many times per month?)*** _____
O Sores on Lips or Tongue O Headaches ***(where and when?)***
O Other Head / Neck Problems _____

_____

_____

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Cardiovascular

O High Blood Pressure O Low Blood Pressure O Chest Pain O Irregular Heartbeat
O Dizziness O Fainting O Cold Hands / Feet O Swelling in Hands / Feet
O Blood Clots O Phlebitis O Difficulty Breathing O Other

Respiratory

O Cough O Coughing Blood O Asthma O Bronchitis
O Pneumonia O Difficulty in Breathing When Lying Down O Tight Chest
O Production of phlegm: Frequency? ***(daily, hourly, etc.)*** _____ ***What Color?*** _____

Gastrointestinal

O Nausea O Vomiting O Diarrhea
O Gas O Belching O Black Stool
O Bad Breath O Rectal Pain O Hemorrhoids
O Constipation O Bloody Stools O Sensitive Abdomen
O Pain or Cramps O Laxative Use: ____***times/wk. type*****:** _____

BOWEL MOVEMENTS
- Frequency: _____
- Color: _____
- Odor: _____
- Texture/Form: _____

Gastro-Urinary

O Pain at Urination O Frequent Urination O Blood in Urine O Urgency to Urinate
O Unable to Hold Urine O Kidney Stones O Venereal Disease O Impotency
O Wake Up to Urinate ***How Often?*** _____***/night; times:*** _____ O Other Gastro-Urinary Problems

Pregnancy and Gynecology

O # of Pregnancies: _____ O Number of Births: _____ O Premature Births: _____ O Miscarriages: _____
O Age at First Menses: _____ O Period Length: _____ ***days*** O Duration: _____ O Irregular Periods: _____
O Flow ***(describe below)*** O Clots O Last PAP: _____ O Last Menses: _____
O Vaginal Discharge O Vaginal Sores O Breast Lumps O Menopause: _____
O Birth Control: ***Type:*** _____ ***Duration:*** _____ O Changes in Body / Psyche prior to Menstruation?

Musculoskeletal

O Neck Pain O Muscle Pains O Back Pain ***(where?)*** O Joint Pains ***(where?)***
O Other Joint or Bone Problems?

Neuropsychological

O Seizures O Areas of Numbness O Poor Memory O Concussion
O Depression O Anxiety O Bad Temper O Easily Stressed
O Treated for emotional problems ***(explain below)*** O Considered/Attempted Suicide
O Other neurological or psychological problems? ***(explain below)***

Classical

PREFERENCE	MOST LIKED	LEAST LIKED	Body Type
Season			**Color**
Taste			**Tone**
Climate			**Yin/Yang**
Time of Day			**Firm/Weak**
Temperature			**Hot/Cold**
			Surface/Interior

I certify that the above accurately describes my symptoms as of the date of this form:

_____ _____
Signature of Patient Date