ALL PRO Health Center

5220 Clark Ave, Ste. #445
Lakewood, CA 90712
(562) 867-6183
(562) 866-4740 FAX

56 East Duarte Road,
Arcadia, CA 91006
(626) 447-4888
(626) 447-4010 FAX

PERSONAL HISTORY QUESTIONAIRE

Name_____ Date_____

Address_____ Email_____

City_____ State_____ Zip _____

Day Phone_____ Evening Phone_____

Social Security_____ - ____ - _____ Date of Birth_____ Sex_____

Age_____ Height_____ Weight_____ Occupation_____

Emergency Contact:_____Number:_____

Reason for today's visit

_____

_____

How did you hear about us? (Please select one of the following)

□ Friend □ Family Member □ Walk-In □ Internet □ Referral

Past Medical History

Have you had any of the following condition(s)? Please check all that apply:

□	AIDS/HIV	□	Drug Addictions	□	Lymph Nodes removed
□	Alcoholism	□	Emphysema	□	Multiple Sclerosis
□	Allergies (food, medication)	□	Fibromyalgia	□	Pacemaker
		□	Heart Disease	□	Seizures
□	Asthma	□	Hepatitis A, B, or C	□	Sinus Infections
□	Cancer	□	Herpes	□	Tuberculosis
□	Diabetes	□	Joint Replacements	□	Other, please list

Family Medical History (Please list any significant family illnesses such as high blood pressure, heart disease, diabetes, etc.)

Mother_____

Father_____

Siblings_____

Grandparents_____

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Date of last physical exam?_____ Are you currently receiving any other form of treatment? _____ If Yes, please explain and list treating doctors name and number: _____

_____

_____

Please list all medications and/or supplements you are currently taking:

_____

_____

_____

Cardiovascular (Please check all that apply)

□	Chest Pain	□	Palpitations	□	Varicose Veins
□	Colds hand/feet	□	Irregular Heart Beat	□	Poor Circulation
□	High/Low BP	□	Easy Bruising	□	Other

Respiratory, Eyes, Ears, Throat (Please check all that apply)

□	Snoring	□	Coughing	□	Chronic Bronchitis
□	Frequent Colds	□	Shortness of Breath	□	Nose Bleeds
□	Painful/Dry Eyes	□	Poor vision	□	Dizziness
□	Dry mouth	□	Ear Pain/Ringing in Ears	□	Migraines/ Headaches
□	Other_____				

Do you smoke? □ No □ Yes _____packs/day _____years smoked

Gastrointestinal (Please check all that apply)

□	Belching	□	Nausea/Vomiting	□	Ulcers
□	Bloating	□	Acid Regurgitation	□	Heartburn
□	Hernia	□	Severe stomach pain	□	Indigestion

Bowel movements: How often?_____ time(s)/day) _____days/week

Usual time of day movement is made?

Stool consistency/contents (check all that apply):

□	Irregular	□	Constipation	□	Diarrhea	□	Gas
□	Burning	□	Hemorrhoids	□	Undigested food	□	Blood
□	Mucus	□	Itching				

Urinary (Please check all that apply)

□	Frequent urination	□	Incontinence	□	Pain	□	Dribbling
□	Trouble starting	□	Blood	□	Kidney Stones	□	Burning
□	Urinary tract infections			□	Other_____		

How often? _____times/day Color: □ Pale Yellow □ Dark Yellow

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Muscles, Joints, and Bones

Do you have pain or tightness? _____ If Yes, where? _____

_____

Describe the pain (circle all that apply): Sharp, Dull, Aching, Numb, Superficial pain, Deep pain, Burning, Tingling, Shooting

□ Pain worse/better with pressure □ Pain worse in am/pm
□ Swollen joints □ Arthritis □ Cramping □ Fractured bones
□ Other _____

Skin & Hair (Please check all that apply)

□ Dry Skin □ Skin rashes □ Itching □ Acne
□ Eczema □ Hives □ Hair loss □ Early graying
□ Other_____

Exercise, Energy, Stress and Sleep

How is your energy on a scale of 1-10 (10 being the highest)?_____
Do you fatigue easily?_____
Do you exercise?_____ How often?_____ Type:_____
Do you have a lot of stress?_____
What do you do to relieve stress?_____
Are you currently or have you experienced depression?_____Anxiety?_____
How many hours do you sleep at night?_____ Do you wake up refreshed?_____
Difficulties falling asleep?_____ Staying asleep?_____ Waking up?_____
Dream disturbed sleep?_____ Any other?_____

Women

Age of first menstruation?_____ Age menses ceased?_____
Days between cycles?_____ Number of days of flow?_____ Color:_____
(Please check all that apply) □ Irregular menstruation □ Spotting between cycle
□ Heavy flow □ Light flow □ Vaginal itching/burning
□ Clots □ Cramping □ Bloating
□ Pain before cycle □ Pain during cycle □ Pain after cycle
Any vaginal discharge? _____ Color?_____ Thick or thin?_____
Are you currently pregnant?_____ Are you trying to conceive?_____
Are you currently on birth control?_____If Yes, which kind?_____
How far along are you in your current cycle?_____

Men (Please check all that apply)

□ Prostatitis □ Impotence □ Penis discharge of mucus/blood
□ Other_____