

Date:

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (<i>Last, First, M.I.</i>):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Street address	Apt	City	Postal Code
Daytime phone:		Evening phone:	
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Referred by:		Date of last physical exam:	
Email Address			

PERSONAL HEALTH HISTORY

Childhood illness <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
Immunizations and dates	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>
	<input type="checkbox"/> DPT	<input type="checkbox"/> Hib
Briefly describe bad effects from vaccination (if any)		
Major complaints in order of importance to you		
Complaint	Since	Causes
1.		
2.		
3.		
4.		
Surgeries or Major Injuries		
Year	Reason for Surgery or Type of Injury	Complications?
Are there any circumstances or conditions (illnesses) from which you have never been totally well since?		
Year	Condition	

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Have you had homeopathic treatment before?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician	Treated for	Date	

Are you currently under the care of a Physician?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician	Treated for	Date	

Check each of the following conditions you have had			
<input type="checkbox"/> Abscesses	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergies	<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chickenpox
<input type="checkbox"/> Cold sores	<input type="checkbox"/> Colitis	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Goiter
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Gout	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Herpes genitalia	<input type="checkbox"/> Influenza	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Miscarriage
<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Parasites	<input type="checkbox"/> PID
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Prostatitis	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Rubella	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Skin disease	<input type="checkbox"/> Strep throat	<input type="checkbox"/> Stroke	<input type="checkbox"/> Sunstroke
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Venereal warts	<input type="checkbox"/> Warts	<input type="checkbox"/> Whooping cough	<input type="checkbox"/> Worms

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the drug	Strength	Any adverse symptoms

Allergies to medications	
Name the drug	Reaction you had

Please turn to next page

WOMEN ONLY

Age at onset of menstruation:	
Number of pregnancies	
Miscarriages	Abortions
Complications from any of the above:	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Cola
	# cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	How much and how often?		

FAMILY HEALTH HISTORY

	AGE/AGE DECEASED	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
Paternal Aunts	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
Paternal Uncles	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
Maternal Aunts	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
Maternal Uncles	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		
Check any of the following conditions present in your family					
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Depression		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Gout		
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Insanity	<input type="checkbox"/> Paralysis		
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Skin disease	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Other (please describe)					

MEDICAL/PROFESSIONAL WAIVER: PLEASE READ THE FOLLOWING CAREFULLY (under 19yrs of age require a parent or legal guardian's signature).

I the undersigned, understand that **Nicholas Mazzoli is a classically trained Homeopath and not a licensed medical doctor**. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Nicholas Mazzoli, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current fee schedule. I also acknowledge that cancellation of appointments with less than 24hrs notice may result in a charge of \$100.00.

Patient's name

Signature (parent/guardian)

Witness

Date