

Eugene Bubis, ND,LDN

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First Name				Last Name				Sex		Date of Birth		
Address												
City				State		Zip			SS Number			
Home Phone				Work Phone				E-Mail				
Occupation				Hours Per Week		Employer						
Marital Status:	<input type="checkbox"/>	<i>Married</i>	<input type="checkbox"/>	<i>Separated</i>	<input type="checkbox"/>	<i>Divorced</i>	<input type="checkbox"/>	<i>Widowed</i>	<input type="checkbox"/>	<i>Single</i>	<input type="checkbox"/>	<i>Partnered</i>
Live With:	<input type="checkbox"/>	<i>Spouse</i>	<input type="checkbox"/>	<i>Partner</i>	<input type="checkbox"/>	<i>Relatives</i>	<input type="checkbox"/>	<i>Friends</i>	<input type="checkbox"/>	<i>Alone</i>	<input type="checkbox"/>	<i>Parents</i>
Person to Reach in an Emergency						Relationship				Phone		

HEALTH QUESTIONNAIRE

We can help you achieve your health goals only if we completely understand you on physical, mental, and emotional levels. Please complete this questionnaire as thoroughly as possible, and mark anything you do not understand with a question mark.

List Your Most Important Health Problems in Order of Importance

1.												4.											
2.												5.											
3.												6.											

When, Where, and WHY did You Last Receive Medical or Health Care?

Family History

Check What Applies	Father		Mother		Brothers		Sisters		Spouse		Child	
Age Now (Age at Death)	()		()		()		()		()		()	
General Health (is/was)	Good	Poor	Good	Poor	Good	Poor	good	Poor	Good	Poor	Good	Poor
Cancer												
Diabetes												
Heart Disease												
High Blood Pressure												
Stroke												
Epilepsy												
Mental Illnesses												
Asthma, Hayfever, Hives												
Allergies												
Anemia												
Kidney Diseases												
Glaucoma												
Tuberculosis												
Cause of Death												

Childhood Illnesses

Immunizations

Scarlet Fever	Yes	No	Measles	Yes	No	Polio	Yes	No	Hepatitis B	Yes	No
Mumps	Yes	No	Rheumatic Fever	Yes	No	DTP	Yes	No	Other		
Diphtheria	Yes	No	German Measles	Yes	No	MMR	Yes	No	Other		

List Hospitalizations and Surgeries You Have Had

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List X-Rays, CAT Scans, MRI's, or Other Special Studies You Have Had

										Electrocardiogram	Yes	No
										Electroencephalogram	Yes	No

List Any Foods, Drugs, or Other Substances You are Allergic to

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Medications You are Currently Using

Laxatives	Yes	No	Tranquilizers	Yes	No	Appetite Suppress.	Yes	No	Antacids	Yes	No
Cortisone	Yes	No	Pain Relievers	Yes	No	Thyroid Meds	Yes	No	Sleeping Pills	Yes	No

List Prescription Medications, Over The Counter Medications, Vitamins and Other Supplements You are Taking

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Exercise	Yes	No	Awaken Rested	Yes	No	Smoke Tobacco	Yes	No	List Your Main Hobbies			
Eat 3 Meals/Day	Yes	No	Enjoy Your Job	Yes	No	Drink Alcohol	Yes	No				
Sleep Well	Yes	No	Be Outside	Yes	No	Use Drugs	Yes	No				

REVIEW OF SYSTEMS

Y - a condition you have now, **N** - never had, **P** - a condition you had in the past

GENERAL				RESPIRATORY			Length of Cycle						
Weight		Height		Cough	Y	P	N	Are Cycles Regular		yes	no		
Weight 1 Year Ago				Sputum	Y	P	N	Bleeding Between Periods		Y	P	N	
Hormonal Disorders		Y	P	N	Spitting Up Blood	Y	P	N	Pain During Intercourse		Y	P	N
Excessive Thirst or Hunger		Y	P	N	Wheezing	Y	P	N	PMS, Painful Menses		Y	P	N
Heat or Cold Intolerance		Y	P	N	Asthma	Y	P	N	Excessive Menstrual Flow		Y	P	N
Fatigue		Y	P	N	Bronchitis	Y	P	N	Birth Control Type (if any)				
SKIN				Pneumonia	Y	P	N	Number of Pregnancies					
Rashes		Y	P	N	Pleurisy	Y	P	N	Number of Live Births				
Eczema, Hives		Y	P	N	Emphysema	Y	P	N	Number of Miscarriages				
Acne, Boils		Y	P	N	Difficulty Breathing	Y	P	N	Number of Abortions				
Itching		Y	P	N	Painful Breathing	Y	P	N	Difficulty Conceiving		yes	no	
Color Change		Y	P	N	Shortness of Breath	Y	P	N	Menopausal Symptoms		Y	P	N
Lumps		Y	P	N	Tuberculosis	Y	P	N	MALE REPRODUCTIVE				
Night Sweats		Y	P	N	CARDIOVASCULAR and BLOOD			Hernias		Y	P	N	
HEAD				Heart Disease	Y	P	N	Testicular Masses		Y	P	N	
Headaches		Y	P	N	Angina, Chest Pain	Y	P	N	Testicular Pain		Y	P	N
Head Injury		Y	P	N	High Blood Pressure	Y	P	N	Prostate Problems		Y	P	N
EYES				Murmurs	Y	P	N	BREASTS (both sexes)					
Impaired Vision		Y	P	N	Rheumatic Fever	Y	P	N	Do You Do Self Exams		Y	P	N
Glasses or Contacts		Y	P	N	Swelling in Ankles	Y	P	N	Lumps		Y	P	N
Eye Pain		Y	P	N	Palpitations, Fluttering	Y	P	N	Pain, Tenderness		Y	P	N
Tearing or Dryness		Y	P	N	Easy Bleeding or Bruising	Y	P	N	Nipple Discharge		Y	P	N
Double Vision		Y	P	N	Anemia	Y	P	N	SEXUAL SPHERE				
Glaucoma		Y	P	N	GASTROINTESTINAL			Are You Sexually Active		yes	no		
Cataracts		Y	P	N	Heartburn	Y	P	N	Sexual Preference	Heterosexual			
EARS				Trouble Swallowing	Y	P	N	Bisexual					
Impaired Hearing		Y	P	N	Change in Thirst or Appetite	Y	P	N		Homosexual			
Ringing		Y	P	N	Nausea	Y	P	N	Sexual Difficulties		Y	P	N
Earache		Y	P	N	Vomiting	Y	P	N	Discharges, Growths		Y	P	N
Dizziness		Y	P	N	Vomiting Blood	Y	P	N	Venereal Diseases		Y	P	N
NOSE and SINUSES				Bowel Movement Frequency				MUSCULOSKELETAL					
Frequent Colds		Y	P	N	Blood in Stool	Y	P	N	Arthritis, Joint Complains		Y	P	N
Nose Bleeds		Y	P	N	Indigestion, Excessive Gas	Y	P	N	Broken Bones		Y	P	N
Stuffiness		Y	P	N	Jaundice (yellow skin)	Y	P	N	Muscle Spasms or Cramps		Y	P	N
Hay Fever		Y	P	N	Liver Diseases	Y	P	N	NEUROLOGIC and VASCULAR				
Sinus Problems		Y	P	N	Gall Bladder Diseases	Y	P	N	Memory Loss		Y	P	N
MOUTH and THROAT				Ulcer	Y	P	N	Numbness or Tingling		Y	P	N	
Frequent Sore Throat		Y	P	N	Hemorrhoids	Y	P	N	Paralysis		Y	P	N
Sore Tongue		Y	P	N	URINARY			Seizures, Fainting		Y	P	N	
Gum Problems		Y	P	N	Pain on Urination	Y	P	N	Muscle Weakness		Y	P	N
Hoarseness		Y	P	N	Increased Frequency	Y	P	N	Cold Hands or Feet		Y	P	N
Dental Cavities		Y	P	N	Frequency at Night	Y	P	N	Deep Leg Pain		Y	P	N
NECK				Inability to Hold Urine	Y	P	N	Varicose Veins		Y	P	N	
Lumps		Y	P	N	Frequent Infections	Y	P	N	EMOTIONAL				
Swollen Glands		Y	P	N	Kidney Stones	Y	P	N	Depression		Y	P	N
Goiter		Y	P	N	FEMALE REPRODUCTIVE			Mood Swings		Y	P	N	
Pain or Stiffness		Y	P	N	Age Menses Began				Anxiety, Tension		Y	P	N