Original Date:
Dates Revised:

STRENGTH SMITH TRAINING SYSTEMS LLC
HEALTH HISTORY QUESTIONNAIRE

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

Name (Last, First, M.I.):	M F	**DOB:**
Marital status:	Single Partnered Married Separated Divorced Widowed	
How did you hear about us:		**Date of last physical exam:**

Home			
Home Address	**City**	**State**	**Zip**

Home Phone	**Work/Cell Phone**	**Email**

Primary Care

Primary Care Doctor:

Office Phone:	**Email:**

Clinic Address:

Emergency Contact

Primary Emergency Contact Name:

Relationship:

Home Phone	**Work/Cell Phone**	**Email**

Secondary Emergency Contact Name:

Relationship:

Home Phone	**Work/Cell Phone**	**Email**

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	Tetanus	Pneumonia
	Hepatitis	Chickenpox
	Influenza	MMR Measles, Mumps, Rubella

Circle all the present conditions. Underline the past conditions. List approximate date condition began:

Acid Reflux	Constipation	Headache	Migraines	Low Blood Pressure
AIDS/HIV	Depression	Heart Disease	Memory Loss	High Cholesterol
Allergies	Diabetes	Hepatitis	Miscarriage	Psychiatric Care
Anemia	Diarrhea	Herniated Disc	Mononucleosis	Rheumatoid Arthritis
Anorexia	Difficulty Sleeping	Herpes	Multiple Sclerosis	Stroke
Appendicitis	Dizziness	High Blood Pressure	Muscle Weakness	Seizures
Asthma	Emphysema	Insomnia	Mumps	Shortness of Breath
Bloating	Epilepsy	Irritability	Osteoporosis	Nausea
Bronchitis	Fainting	Kidney Disease	Osteopenia	Vertigo
Bulimia	Fatigue	Liver Disease	Pacemaker	Nervousness/Anxiety
Cancer	Fever	Light Sensitivity	Indigestion	Suicide Attempt
Cataracts	Fractures	Loss of Smell	Pneumonia	Scoliosis
Chicken Pox	Glaucoma	Loss of Libido	Parkinson's Disease	Thyroid Disorder
Cold Sweats	Goiter	Low Energy	Polio	Tonsillitis
Cold Feet or Hands	Gonorrhea	Measles	Prostate Disorder	Tuberculosis
TMJ	Ulcers	Whooping Cough	Vaginal Infection	Prosthesis

List any medical problems that other doctors have diagnosed:

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	Yes	No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Dosage & Frequency Taken	Reason for Taking

Allergies to Medications	
Name the Drug	Reaction You Had

Allergies to Food	
Name the Food	Reaction You Had

Allergies to Environment	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.	
	Sedentary (No exercise)

Exercise (Circle One)	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Do you follow any diet or dietary restrictions? Example: Vegetarian, Vegan, Paleo etc.				Yes	No
	If yes please describe:					
	Are you on a physician prescribed medical diet?				Yes	No
	# of meals you eat in an average day?					
	Rank salt intake	Hi	Med	Low		
	Rank fat intake	Hi	Med	Low		
Caffeine	□ None	Coffee	Tea	Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				Yes	No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				Yes	No
	Have you considered stopping?				Yes	No
	Have you ever experienced blackouts?				Yes	No
	Are you prone to "binge" drinking?				Yes	No
	Do you drive after drinking?				Yes	No
Tobacco	Do you use tobacco?				Yes	No
	Cigarettes – pks./day		Chew - #/day	Pipe - #/day	Cigars - #/day	
	# of years	Or year quit				
Drugs	Do you currently use recreational or street drugs?				Yes	No
	If yes, please describe:					
	Have you ever given yourself street drugs with a needle?				Yes	No
Sex	Are you sexually active?				Yes	No
	If yes, are you trying for a pregnancy?				Yes	No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				Yes	No
Personal Safety	Do you live alone?				Yes	No
	Do you have frequent falls?				Yes	No
	Do you have vision or hearing loss?				Yes	No
	Do you have an Advance Directive and/or Living Will?				Yes	No

Would you like information on the preparation of these?	Yes	No
Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	Yes	No

FAMILY HEALTH HISTORY

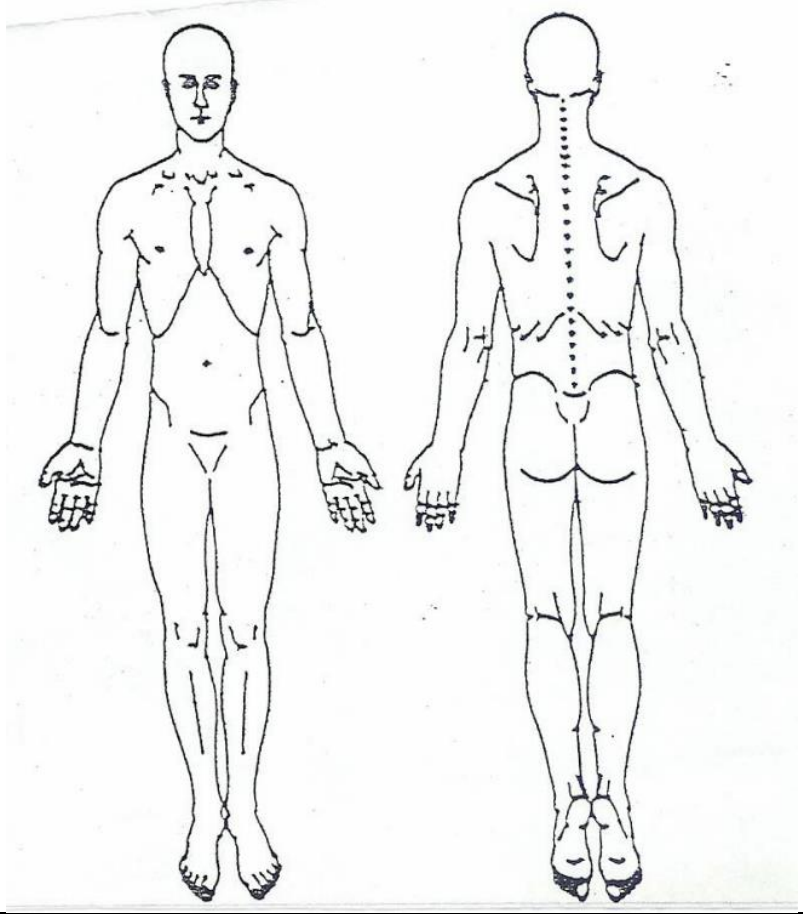
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**		
Mother					
Sibling					
			Grandmother Maternal		
			Grandfather Maternal		
			Grandmother Paternal		
			Grandfather Paternal		

PAIN DIAGRAM AND PAIN RATING

Please use the diagram below to indicate the symptoms you have experienced over the last 24 hours. Use the key to indicate the type of symptoms

Key:

Pins and Needles=	0000
Burning=	xxxx
Stabbing=	////
Deep Ache=	zzzz



Please rate your current level of pain on the following scale (circle or highlight one):

0. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10

0=No Pain 10= Worst Pain Imaginable

Please rate your worst level of pain in the last 24 hours on the following scale (circle or hghlight one):

0. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10

0=No Pain 10= Worst Pain Imaginable

Please rate your best level of pain in the last 24 hours on the following scale (circle or highlight one):

0. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10

0=No Pain 10= Worst Pain Imaginable

MENTAL HEALTH

Is stress an issue for you?	Yes	No
Do you feel depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Do you cry frequently?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counselor?	Yes	No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every_____days		
Heavy periods, irregularity, spotting, pain, or discharge?	Yes	No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	Yes	No
Have you had a hysterectomy, or Cesarean?	Yes	No
Any urinary tract, bladder, or kidney infections within the last year?	Yes	No
Any blood in your urine?	Yes	No
Any problems with control of urination?	Yes	No
Any hot flashes or sweating at night?	Yes	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	Yes	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	Yes	No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	Yes	No
If yes, # of times		
Do you feel pain or burning with urination?	Yes	No
Any blood in your urine?	Yes	No
Do you feel burning discharge from penis?	Yes	No
Has the force of your urination decreased?	Yes	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Yes	No
Do you have any problems emptying your bladder completely?	Yes	No
Any difficulty with erection or ejaculation?	Yes	No
Any testicle pain or swelling?	Yes	No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

Skin	Chest/Heart	Recent changes in:
Head/Neck	Back	Weight
Ears	Intestinal	Energy level
Nose	Bladder	Ability to sleep
Throat	Bowel	Other pain/discomfort:
Lungs	Circulation	