Date Completed: ______________

Destination Health®

Comprehensive Health History

Name: ________________________ ____________________ ____ Age: ____ Date of birth: __________
Last *First* *M.I.*

Social History:

Place of Birth: ____ Race: _____________________
City, State, Country

Religious affiliation or preference? ____

Marital Status: Married __ Divorced __ Separated __ Widowed __ Common law __ Engaged __ Single ____

Number of people who live with you (if any):
# of sons ____; # of daughters ____; # of step-children ____; # grandchildren ____; # of parents/in-laws ___
Other ____

Do you have any children that do not live with you? If so, please give gender and ages:
____

Deceased children: ____

Occupation: _________________ _____________________ ___________ ____________________
Title/position *Company* *Years* *City*

Are you the sole provider for your family? _________ Do you enjoy your job? _____________________
Education: High school diploma____ GED ____ less than 4 years college _____ College graduate _____
Master's degree ____ Doctorate ______ Post-Doctorate _____

Describe any learning disabilities: ____

Languages spoken other than English ____

Overall Health Status:

How would you describe your overall general health? Poor ___; Fair ___; Good ____; Excellent____

What areas of your health do you feel need improvement?
____

Physical, Emotional, or Spiritual

Allergies: (*Please circle if applicable*):
(A true allergy is a body rash or difficulty breathing/swelling)

Foods: eggs; berries; peanuts; milk; wheat; gluten
Other: ____

Environmental: dust; pollen; ragweed; mountain cedar; grasses; dogs; cats; bee stings; latex
Other: _______________________________________

Medications: penicillin; -mycins; tetanus.
Other: _____________; ____________; _____________
_____________; ____________; _____________

Immunizations: (please provide a copy of your vaccine record for your file)

Year of last: flu shot _____; tetanus vaccine _____; pneumonia vaccine _____;
TB skin test _____.
Have you ever had a positive TB skin test? ________.
If yes, what year? ____Did you require treatment? _______
Year of last chest X-Ray for positive TB skin test ______
Provide dates of COVID-19 vaccinations________________________________
Have you had chicken pox?____When?______
Have you had Varivax (vaccine for chicken pox)? ______when? _____

Current Prescription Medication

Name of Medication	Strength	Directions	How often taken correctly?

Current Non-Prescription (*Over the Counter*) Medications Taken Routinely

(ex: Aspirin, vitamins, laxatives, sleeping pill, antihistamines, pain relievers)

Medications	Strength	Daily dose

Preventative tests/exams:

Year of last:

- Complete history and physical __________ Provider ________________________
- OB/Gyn exam ___________ Provider______________________________________
- Colonoscopy____________ Provider_______________________________________

  Results? _____________________
- Bone density test __________________Facility_____________________________

  Results? ______________________
- Mammogram ______________________ Facility ____________________________

  Results? ______________________
- Chest Xray _________________________ Facility ____________________________

  Results? ______________________
- Cardiac testing (stress, echo, etc…) _________________Facility _____________

  Results? ______________________

Other Health Care Specialists

	Name	**Mo/Yr Last Seen**	**Frequency of Visits**	**Phone Number**
Eye Doctor				
Dentist				
Allergist				
Cardiologist				
GI Doctor				
Rheumatologist				
Oncologist				
Therapist/Psychologist				
Psychiatrist				
Chiropractor				
Massage Therapist				
Urologist				
OB/Gynecologist				
Other				

May I speak to all of them if needed about your health care? ____

Exceptions? ____

Family History: Only **biological** family. Siblings from ***oldest to youngest*** please.

	Living (age)	Deceased (age)	Medical Problems *(from list below)	Cause of Death
Mother				
Father				
Sister				
Sister				
Sister				
Brother				
Brother				
Brother				
Mat. Grandmother				
Mat. Grandfather				
Pat. Grandmother				
Pat. Grandfather				
Other Siblings				
Other Siblings				

*Medical problems for table above: diabetes (DM); heart disease (HD); high blood pressure (HTN); Asthma; Alcoholism;

Glaucoma; Breast cancer; Prostate cancer; colon cancer; other cancers; thyroid disease; Rheumatoid arthritis (RA); lupus (SLE); High cholesterol or triglycerides (chol, TG); bleeding or clotting problems such as hemophilia or factor deficiencies; mental illness; osteoporosis; migraine headaches; feel free to list other diseases you feel may be important for me to know.

Past Medical History:

Check if you have *ever* been ***diagnosed*** with any of the following by a doctor:

Heart disease__; High blood pressure__; Stroke; Cancer (type) _________; high cholesterol or triglycerides__; asthma ___; alcoholi
glaucoma ____; thyroid disease____; RA ___; lupus ___; hemophilia ____; G6PD ____; depression ____;
anxiety disorder ____; manic depression (bipolar) ____; schizophrenia _____; obsessive-compulsive disorder ____;
eating disorder ____; genital herpes _____; HPV ____; other sexually transmitted disease(type) ________; rheumatic fever ___;
polio ____; prostatitis ____; mono ___; shingles ____; diabetes ___; anemia ___; migraine headaches ____; endometriosis ____;
protein in urine ____; phlebitis____; deep vein thrombosis (blood clot) ______; pulmonary embolism ______; aneurysm _____;
emphysema ____; heart murmur _____; ulcer (esophagus, stomach, duodenum) _____; kidney stones _____; pancreatitis ____;
infertility ____; gout ____; seizures _____; birth defect; _______; physical disability ______; scoliosis _____.
osteoporosis ___; osteoarthritis ____; fibromyalgia _____; chronic fatigue syndrome ______; Sjogren's syndrome ____;
scleroderma______; sarcoidosis ____; sleep apnea____; narcolepsy ____; psoriasis ____; eczema ____ ; rosacea ____;
TMJ disorder _____; hearing loss ____; heart rhythm abnormality ____; Crohn's disease___; Ulcerative colitis ___.
incontinence; _____impotence ___.
Other ____

Surgery: Please list all surgeries you have had and the approximate year. Include cosmetic surgeries.

____
____
____

Hospitalizations: Please list reasons for any hospitalizations other than for the above surgeries.

____
____
____

Injuries: Please list any major injuries other than sprains or strains.
(examples: car accident with broken leg)____
____
____
____

Habits: (please place a check by your response)
How often do you drink alcoholic beverages? Daily ____ weekly___ monthly____less than once a month_____never___.
What do you drink? Wine____ beer____mixed drinks____. How much do you consume at one sitting? _______________(ounces)
I stopped drinking alcohol in (year) __________ because of alcoholism________health________personal reasons______.
Has drinking alcohol ever caused you problems with the law, work, or relationships? Yes______ No______

Do you smoke cigarettes? yes_____ no_____If yes, how many packs each day?_____for how many years total? _______ .
Did you smoke previously? Yes____no____If yes, how many packs per day? _________ for how many years? _________.
Quit date was _________________________.

Have you used or do you currently use any other tobacco/nicotine products? Yes__No__.
If yes, check what type? dip____chew____pipe_____ vaping/e-cigarettes _______ other _________
For how many years? ______. Quit date _________.

Have you ever tried to stop tobacco/nicotine products? Yes____No____. If yes, what method did you try? ___________________.
How long were you successful in your efforts? ____.

How often do you smoke marijuana? _______; take amphetamines? ______; use cocaine? ____
use other mind-altering drugs? ____________

If you use tobacco, alcohol, or recreational drugs, how motivated are you to quit? Very____ Somewhat_____ Not at all______

Weight and Nutrition:

My highest adult weight ___________ Date_______
My lowest adult weight ___________ Date_______

At what weight have you felt your best? ___________
Are you happy with your current weight? Yes ___ No___

If no, have you ever received nutritional counseling in the past? Yes ____ No ____

How many meals do you eat per day? _____ Do you eat breakfast regularly? _______ What fluids do you drink daily?
Cups of coffee _____, number of sodas (diet or regular) _____ glasses of water ____ glasses of juice ______ alcohol (oz) _____
Do you ever binge (eat large amounts of food when you are not hungry)?
Yes____ No_____.
Do you know if you are eating or drinking for reasons other than hunger or thirst?
Yes_____No_____ If yes, please explain trigger (s): ______________________________
____

Do use any other caffeine products? Yes _____ No _____
If yes, how often? ________
What products do you use? ____

Do you ever vomit or use laxatives for weight control? Yes___ No____
If yes, how often? ________ If no, did you ever use these methods in the past?
Yes___ No____ If yes, date stopped _______.

Do you have any food intolerances or special dietary needs? Yes _____ No_____
If yes, please list: ____

What foods do you eat that you would consider “unhealthy”? _________________
____
How often are they consumed? per day _____ per week_____per month________

Weight and Nutrition (continued):

Do you feel confident on how to interpret food labels? Yes_____ No______

Not Important Very important
0 1 2 3 4 5 6 7 8 9 10
Using the scale above, score how you would rate the importance of fitting a healthy diet into your life?

What are the barriers in your life which prevent you from following a healthy diet?
____

____

Exercise/Energy:

How physically active are you? (Circle one):

Very active Active Average Inactive

What do you do for physical activity?
____
____

Do you ever exercise excessively or compulsively in order to lose weight?
Yes___No____

Is there anything that prevents you from being physically active? Yes___No___
If yes, explain: ____
____

Not important Very important
0 1 2 3 4 5 6 7 8 9 10
Using the scale above, score how would you prioritize exercise in your life now?

Are you interested in making it a higher priority going forward? Yes___No___

Is your daily schedule regular, or does it change from day to day? ____________________
_____________________. If you do shift work, please list the hours you work: __________.

What is your overall energy level? (circle one) poor fair average good very good
Is your energy level consistent or quite variable? Consistent ____ Variable____
If you have energy fluctuations, when do you feel them (example: time of day, foods ingested, weather, activity level, seasonal, cyclical)? ____
____
Describe your sleep pattern: ____
____
Do you wake up feeling refreshed? Yes___ No____
Has a sleeping partner ever told you that you snore? Yes___No___
Has a sleep partner ever told you that you stop breathing for short periods of time when you sleep? Yes___ No___
Have you ever been told that you grind your teeth at night? Yes___No___
Do you wake up many mornings with a headache? Yes___No____
If yes, where on your head is it located? _______________________________________

Psychosocial:

What are your hobbies? ____
What additional activities do you do for fun? ____

What is your stress level? (circle one) low average high

What tends to trigger or bring on stress in your life? ________________________________
____

What ways do you find most effective for releasing stress? _________________________
____

Do you find yourself getting upset, agitated or irritated often? Yes___ No___
What emotion(s) do you have difficulty feeling or expressing? _______________________
____

Do you have personal relationships that are nurturing and supportive? Yes____ No____

Not fulfilled Very fulfilled
0 1 2 3 4 5 6 7 8 9 10

Using the scale above, score how fulfilled you are with your primary personal relationship.

Do you have close friends or others that you can confide in? Yes___No___

Is your career and work environment nurturing and supportive? Yes__ No__

What do you consider the main losses you have suffered? ________________________
____

Have you recently noticed any of the following? Check all that apply:

Personality change ____ Difficulty speaking_____Difficulty concentrating___
Confusion____Memory loss_____ Change in speech____ Change in behavior_____
Feelings of sadness or depression_____ Feeling hopeless____Thoughts of self-harm_____
Feelings of anxiety or nervousness_____Feeling guilty____ Tendency
toward repeating things over and over in your head (obsessive thoughts) ___
Tendency to need everything in order, finding yourself counting, or
repeating tasks over and over again (compulsive)____ Superstitious____
Fearfulness ______ Tendency toward pornography ____Tendency toward
gambling____Tendency toward drinking too much alcohol___Tendency
toward dishonesty_____Desire to stay in bed ___ Avoidance of social
activities____Spending hours on the computer or watching TV___
Lack of interest in things you usually enjoy____Increased energy/not needing
sleep_____ Hearing voices___Seeing things other people don't see____
Nightmares____ Tendency to worry____Tendency toward being negative____
Not wanting to eat_____Eating too much______Not caring about personal hygiene/
(hair not combed, not bathing, not wearing makeup when you are accustomed to) _____
Please elaborate on anything that you checked: ______________________ __________
____
____

Do you feel safe in your home? Yes__ No___ Are you happy with the overall
environment of your home (beauty, organization, location)? Yes__ No___
If no, describe what is unsettling to you: _______________________________________
____

Psychosocial (continued):

Do you feel you have ever been or are you currently being emotionally or
physically abused? Yes___ No___ If yes, please explain _________________________
____

Are you comfortable with your relationship with money? Yes__ No__
If no, describe what makes you uncomfortable? (Ex: overspending, wasting,
not saving, too much debt, etc.) ____
____

Have you ever noticed that you keep bumping up against the same problems and
situations in life? Yes___ No__

Are there habits you would like to change? Yes___ No___ If yes, please list:
____

Do you feel that you can see the "big picture" in your life or do you feel stuck in the day-to-day details? ____

How would you describe the spiritual dimension of your life? ____________________
____

What do you see as most important in life? ________________________________
____

Do you feel you have a particular mission or vocation and are you fulfilling it?
____
____

Are you happy with the amount of time you have to relax and have fun? Yes___No__

Sexual history:

Do you consider yourself: (circle one) heterosexual homosexual bisexual

Have you had more than one sexual partner in the last year? Yes ___ No___

Are you fulfilled with your sex life? Yes___ No___.

If not, please explain any physical or emotional concerns________________________
____

Have you ever been a victim of sexual abuse? Yes__ No__ If yes, at what age? _______ Have you received counseling? Yes___ No___ If no, are you interested in counseling? Yes___ No____

Do you feel like you may have ever been drugged prior to having sex? Yes__ No__

Please circle any sexually transmitted disease that you have been diagnosed with in the past: gonorrhea chlamydia syphilis genital herpes HPV (warts)

Have you ever had sex with a known IV drug user? Yes___ No__; prostitute? Yes__ No___; promiscuous partner (a partner that is homosexual or bisexual or has had many sexual partners)? Yes__ No___

Have you ever been tested for HIV (Aids)? Yes___ No___ Date of last test_______.

Sexual history (continued):

Have you ever had a blood transfusion? Yes___ No___ If yes, year ________.

Do you have any tattoos that were done with a previously used needle? Yes____No____

Have you had any injections with a previously used needle? Yes____ No___

Women only:

Age at first period _____ Age you stopped having periods (if applicable) _______

Do you use birth control? Yes___ No___ If yes, please circle any that apply:
condom birth control pill patch Depo-Provera injection
IUD withdrawal family planning diaphragm Partner vasectomy

How many days apart are your menstrual cycles? _____ How long do they last? Days? ____
Do you have cramps that require medication or time off work/school during menstruation?
Yes___ No____ If yes, what medications have you tried worked best? ____________________

List any premenstrual symptoms that bother you:
____

How many times have you been pregnant? _____Age at first pregnancy_____
How many deliveries have you had? _____Number of elective abortions: _____
Number of miscarriages______ Number of vaginal deliveries_____
Number of C-sections_____ Number of living children_______

Date of abnormal pap smear (if applicable) ___________ What treatment was done? ________________________
What was the follow-up interval recommended? _________________________________

How often do you do self-breast exams? (circle) never occasionally monthly
If never, what is your barrier to doing them? ____________________________________
Would you like to be taught how to do them? Yes__ No__

Do you have what you consider a normal sex drive? Yes___ No___
Do you have pain or discomfort with sex? Yes____ No____ If yes, has this been
addressed by a doctor in the past? Yes___ No___

Men only:

Are you having any problem gaining or maintaining an erection? Yes___ No___
If yes, when did you first start noticing a problem? _______

Have you noticed that the penis has started to curve with erections? Yes__ No__

Do you have any ulcers or lesions on the penis? Yes___ No___

Do you have any lumps or swelling of the testicles? Yes___ No___

Are you experiencing any discharge from the penis? Yes___ No___

Have you noticed any blood with ejaculation? Yes____ No____

Do you have pain in one or both testicles? Yes___ No____

Have you previously been treated for prostatitis? Yes___ No___

Have you previously been treated for an infection of the testicles? Yes___ No___

Place a check beside any of the following that are currently applicable.

General:
___fatigue
___dental problems (please specify) ________________
___bleeding gums
___swollen glands
___*none of the above*

Skin:
___sores
___bruising

Genitourinary:
___need to urinate frequently
___ burning with urination
___ urgent need to urinate
___ leakage of urine
___ get up more than once/night to urinate
___ difficulty starting/stopping urination
___ *none of the above*

___hair loss
___nail changes
___ acne
___rash
___dryness
___change in moles
___*none of the above*

Neck:
___masses
___pain with motion
___stiffness
___swelling
___*none of the above*

Head and Eyes:
___headaches; daily? ___ weekly? ___ monthly? ___
___dry eyes
___watery eyes
___eye pain
___blurred vision
___double vision
___sensitivity to light
___seeing spots
___wear glasses? Only for reading? ___ Only for distance? __
___wear contacts
___*none of the above*

Ear/Nose/Throat:
___difficulty hearing
___ringing in the ears
___ear pain
___nasal polyp
___nasal stuffiness
___sinusitis (frequent)
___decrease or absence of sense of smell
___runny nose
___dry mouth
___frequent cold sores or fever blisters
___sore throat
___*none of the above*

Cardiopulmonary:
___cough
___sputum production
___coughing up blood
___shortness of breath (at rest)
___shortness of breath (with activity)
___wheezing
___pain with breathing

Neuromuscular and Musculoskeletal:
___loss of sensation in hands
___loss of sensation in feet
___tingling in hands
___tingling in feet
___dizziness
___seizures
___ pain in joints(list)_______________
___swelling in joints(list)____________
___stiff joints
___deformed joints
___difficulty bending
___muscle pain
___difficulty squatting
___low back pain
___difficulty walking
___difficulty balancing
___difficulty standing
___difficulty lifting
___difficulty stooping
___frequent falls
___heel pain
___weakness
___poor coordination
___*none of the above*

Hematological:
___easy bleeding
___paleness
___*none of the above*

Endocrine:
___always thirsty
___always hungry
___intolerance to cold or heat
___change in hair texture
___increased body hair (women)
___hard to lose weight
___hard to gain weight
___*none of the above*

Gastrointestinal:
___difficulty swallowing
___pain with swallowing
___frequent burping
___heart burn
___frequent use of antacids
___nausea
___vomiting

___fever
___shaking chills
___night sweats
___must sleep on more than one pillow to breathe
___rapid heartbeat
___heart skips a beat
___palpitations
___chest pain
___varicose veins (painful)
___pain in arm, neck, or jaw
___poor circulation
___swelling of ankles or feet
___leg cramps
___fainting spells
___*none of the above*

___vomiting blood
___frequent loose stools
___constipation
___black stools
___mucous in stools
___blood in stools or on toilet paper
___loss of control of bowel movement
___hemorrhoids
___excessive gas
___recurrent hiccups
___feeling of fullness after a small food intake
___pain with passage of a bowel movement
___change in color or appearance of bowel movement
___abdominal pain or cramping
___alternating diarrhea with constipation
___*none of the above*

Safety/ Prevention:

How often do you use seatbelts? ___________________
Do you ride bikes or motorcycles? Yes__ No___ If yes, how often do you wear a helmet? ___________
Do you have guns in the house? Yes___No___. Are there children living in the home or that visit your home frequently? Yes___ No___ If yes, are the guns/ammunition locked up? Yes__ No__
How often do you use sunscreen? ____________ How often do you floss? ____________ brush teeth ____________

End of Life Issues:

Are you an organ donor? Yes___No___ If not, would you like to become one? Yes___No____
Do you have a living will? Yes___ No___
Do you have an Advanced Health Care Directive? Yes___ No___. If yes, have you discussed your wishes and given a copy to your next of kin? Yes___No___. (If you have one, please furnish us with a copy for your record.)
Do you have a Power of Attorney for Health Care? Yes___ No___

Goals and Objectives for Total Health and Well-Being: (Circle all that apply)

For the body . . .	For the mind . . .	For the spirit . . .
Improve energy level	Learn to identify stressors	Learn to "be" in the moment
Improve diet and lifestyle	Reduce overall stress	Learn to relax
Reduce pain	Less trouble handling emotions	To feel at peace
Improve muscle strength	Less upset and irritated	To gain a wider vision of life
Improve stamina	Less anxious	Learn contentment
Less depressed	Learn how to meditate	Develop relationship with God
Improve posture	Improve self-esteem	Improve relationship with yourself
Improve digestion and elimination	Improve work satisfaction	
Improve breathing	Improve personal relationships	

Improve sleep	Reduce negative habits
Improve breath awareness	Learn to see core patterns
Improve skin appearance	Reduce negative thoughts

__________________________________ __________________________

Patient Signature Date