Medical History Questionnaire

Practitioner: Lynne Faires, RHN

Date: 2018-02-18

Client: Sean Seale 2

Personal Health

List any other healthcare practitioners you are currently seeing:

Medical Doctor, Acupuncturist, Massage Therapist

List all medications you are currently taking:

Name	Duration	Reason/Condition
Medication 1	1 month	Condition 1
Medication 2	2 months	Condition 2

List all supplements you are currently taking (herbs, vitamins, minerals, etc…):

Name and Brand	Dose	Reason/Condition
Supplement 1	2 tablets / day (40mg)	Condition 3
Supplement 2	1 tablets, twice per day	Condition 4

List all hospitalizations and surgeries in the last 10 years (include reasons):

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Do you have any silver-mercury fillings? No

List all diagnosed or suspected food allergies/sensitivities:

Category	Food(s)	Reaction(s)
Diagnosed Allergy	Peanuts	Vomiting, hives
Undiagnosed Allergy/Sensitivity	Wheat	Brain fog, stomach ach

List all the health issues or diseases that you suffer(ed) from:

None of the above

How many times per day do you have a bowel movement? 1

You experience: Constipation, Undigested food in stools

Do you consume alcohol?

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Do you or anyone in your household smoke (cigarettes or other)?

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Do you or anyone in your household use recreational drugs?

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Do you have a healthy sex drive? If not, when was the last time you had one?

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List all the fungal infections you have experienced:

None of the above

Family History

List all the health issues or diseases that your family members suffer(ed) from:

Condition	Relative	Onset Age & Comments
Autoimmune disease	Grandparent	30yo / Hashimoto's disease
Allergies	Mother	Unknown / Peanuts

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Males

List all prostate-related issues you have experienced:

Females

How often do you have a menstrual cycle? Every 28 days

List all the changes you have recently noticed:

None of the above

List all the PMS-related symptoms you experience:

Bloating, Headaches, Joint pain

List all the menopause-related symptoms you experience:

None of the above

Are you on birth control pills? Yes

Please describe your pregnancy history (first attempt, birth(s), miscarriage(s), abortion(s), etc…)

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Comments

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