Riegler, Shienvold & Associates

HEALTH & WELLNESS INTAKE QUESTIONNAIRE

The information that you provide in this questionnaire is meant to assist us in providing the best diagnosis and treatment possible. The information you provide is strictly confidential and will become part of your medical record.

Name: _____ **Date:** _____

Current or Referring Doctor: _____ **Date of Last Exam:** _____

How would you rate your present health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any of these communicable diseases? ☐ Tuberculosis ☐ Hepatitis ☐ Other _____

Health and Wellness Information

Do you have any other medical problems? ☐ No ☐ Yes

If Yes, indicate nature of problem: _____

Exercise:	☐ Sedentary (no exercise) ☐ Mild Exercise (climb stairs, frequent walks, golf) ☐ Occasional vigorous exercise (less than 4 times per week for 30 min.) ☐ Vigorous exercise (more than 4 times per week for 30 min.)
Diet:	Current Weight: _____ Have you recently gained/lost weight? (circle one) ☐ No ☐ Yes How much? _____ Are you dieting? ☐ No ☐ Yes If yes, what plan are you using? _____
Caffeine:	Do you use any of the following? ☐ Caffeinated sodas or energy drinks How much? _____ ☐ Tea How much? _____ ☐ Coffee How much? _____
Sleep:	Do you sleep well? ☐ No ☐ Yes If no, check all that apply ☐ Difficulty falling asleep ☐ Sleep apnea ☐ Difficulty staying asleep ☐ Excessive sleep ☐ Restless, tossing and turning
Tobacco:	Do you use tobacco? (check below) ☐ Currently ☐ Previously ☐ Never ☐ Cigarettes ☐ Snuff If previously, how long did you use? _____ ☐ Cigars ☐ Chewing tobacco If previously, when did you quit? _____ ☐ Pipe If currently, how much? _____
Allergies: List any foods or medications that you may be allergic to.	☐ Penicillin ☐ Others (please list) ☐ Sulfa drugs ☐ Aspirin

HISTORY OF ILLNESS OR SYMPTOMS

ILLNESSES: (Have you had or do you have any of the following? Check all that apply.)

- ☐ Jaundice
- ☐ Anemia
- ☐ Alcohol problem
- ☐ Other drug problems
- ☐ Diabetes
- ☐ Bleeding disorder
- ☐ High blood pressure
- ☐ Sickle cell trait
- ☐ Cancer
- ☐ Thyroid disease
- ☐ Epilepsy
- ☐ Head injuries
- ☐ Mumps
- ☐ Migraines
- ☐ Sexually transmitted disease

Please indicate any symptoms, conditions, or surgeries you have had in the categories below.

CATEGORY	***Describe symptoms, conditions, or surgeries***
EYES, EARS, NOSE, THROAT, AND HEAD:	
HEART, and CIRCULATORY SYSTEM:	
LUNGS:	
STOMACH and ABDOMINAL:	
MUSCLES, JOINTS, AND BONES:	
SKIN:	
BLOOD:	
NEUROLOGY:	
GENITO-URINARY, GYNECOLOGICAL:	

MEDICATION — ***Please list all prescription, Over-the-counter, and herbal medications you are taking***

Medication Name	***Dose***	***Medication Name***	***Dose***	***Medication Name***	***Dose***