

Wyndgate Health

970 Raymond Ave., Ste. 101
 St. Paul, MN 55114
 651-493-4566 / Fax: 651-344-0429

Initials:
Appointment:
Date:
BP:
Pulse:
For office use only

ADULT HEALTH HISTORY QUESTIONNAIRE

All information in this Health History is strictly confidential and will become part of the patient's permanent medical record.

Patient Name:								
Patient Home Address:								
Referred to Wyndgate by whom?								
Gender:	Male		Female		Date of Birth:		Age:	
Home Phone:					Cell Phone:			
Work Phone:					Email:			
With whom do you live?								
Health History								
Weight:			Height:			Year Home Built:		
Toxin exposure:	Yes		No					
If you answered Yes, which toxins?								
Any diagnosed medical problems?								
For what three <i>symptoms</i> are you coming to Wyndgate Health?								
1.								
2.								
3.								
When did you first notice the above?								
Were the onset(s) of these symptoms			Sudden		Gradual			
Surgeries & Hospitalizations								
Date:	Surgery Type:	Outcome:			Comment:			

Patient Name: _____

Adult Health History, Wyndgate Health

Your Current Prescribed Medications							
Medication:	Dose:	Per Day:	Date Started:	Comment:			
Medication Allergies							
Medication:	Reactions:						
Your Current Supplements							
Name:	Dose:	Per Day:	Date Started:				
Known Food Allergies							
Food:	Reaction:						
Environmental Sensitivities							
	Perfume		Detergents		Mold		Dogs
	Cosmetics		Dust		Pollens		Cats
	Soaps		Fungus				
	Gasoline		Other:				
List any familial occupational chemical exposures:							

Patient Name: _____

Adult Health History, Wyndgate Health

Health Habits									
Bowel Habits:	Number of Bowel Movements per Day?			per Week?					
	Constipation?			Formed Stools?					
	Diarrhea?			Loose Stools?					
	Excessive Gas?			Stomach Aches?					
Have you had any testing or treatments for the gut?					No			Yes	
If Yes, Please explain:									
Second-hand smoke exposure:		Yes		No					
Do you smoke?		No		Yes		If yes, cigarettes per day?			
If yes, for how many years have you smoked?									
Do you drink alcohol?		No		Yes		If yes, how often per week?			
Do you use recreational drugs?		No		Yes		If yes, how often per week?			
Dietary Habits									
Are you on a special diet?			No			Yes			
If Yes, Please explain:									
Average number of daily meals?				Average Number of Daily Snacks?					
What is your primary source of water consumption?									
	Tap Water		Well Water		Bottled Water		Filtered Water		
Have you had your water tested?					No		Yes		
If Yes, what were the results?									
Servings or cups per day of following:									
Protein		Sweets		Carbohydrates					
Dairy		Fruits		Vegetables					
Coffee		Tea		Cola					

Patient Name: _____

Adult Health History, Wyndgate Health

Sleep Habits					
Do you have difficulty:					
Falling asleep		Staying asleep		Waking up	None
Dream recall?		None		Moderate	Vivid
Sleep walking?		None		Sometimes	Frequently
Sleep talking?		None		Sometimes	Frequently
Family Health History					
	No		Yes	Are you adopted and without a birth family health record?	
<i>Use Below Relative Codes to indicate who in the family has experienced any of these health issues.</i>					
Health Issue	Relative Code		Health Issue	Relative Code	
ADD / ADHD			Bipolar disorder		
Alcohol abuse			Cancer		
Anxiety			Depression		
Arthritis			Diabetes		
Asthma			Eczema		
Food allergies			Stroke		
Heart disease			Suicide attempts		
High blood pressure			Thyroid		
Memory issues			Ulcers		
Psoriasis			Violence / criminal		
Psychosis			OCD		
Relative Codes for Use Above					
Code	Definition	Code	Definition	Code	Definition
M	Mother	MA or MU	Maternal Aunt / Uncle	MGM or MGF	Maternal grandmother / grandfather
F	Father	PA or PU	Paternal Aunt / Uncle	PGM or PGF	Paternal grandmother / grandfather
S	Sister				
B	Brother				

Patient Name: _____

Adult Health History, Wyndgate Health

Your Mental Health									
If you answer Yes, please explain or describe.									
	Yes		No	Anxiety disorder					
	Yes		No	Anger					
	Yes		No	Behavior					
	Yes		No	Sensory					
	Yes		No	Depressive disorders					
	Yes		No	Autism, ADHD					
	Yes		No	Eating disorders					
	Yes		No	OCD					
	Yes		No	Mood disorders					
	Yes		No	Psychotic disorders					
Racing thoughts			Easily distracted			Learning disabilities			
"Foggy" brain			Intrusive thoughts			Mood swings			
Women Only									
Menstruation onset age?			Pregnancies			Live births			
"Hot flashes"		PMS		Excessive cramping			Excessive bleeding		
Vaginal dryness		Low libido		Hysterectomy			Menopause		
Post partum depression									
Other Issues									
Yeast infection			Dry skin / hair / eyes			Recent weight gain			
Allergies			Eczema			Recent energy change			
Sweets craving			Headaches			Recent sleep changes			
Memory loss			White spots on fingernails			Frequent infections			
Mood swings			Frequent colds			Clumsiness			
Peeling fingernails			Fears			Excessive thirst			
						Other...			

Patient Name: _____