Health History Questionnaire ©
Dr. Glenn Wilcox LLC

Please fill out this questionnaire. It will help Dr. Wilcox provide you with a complete holistic, integrated medical evaluation. Although it is 10 pages, most of it is checkboxes. However, the time you invest will help Dr. Wilcox better understand your health issues and will save you time and fees during your initial consultation. If you have medical records, including test results or imaging reports from the last year or two, please bring those with you or send them to us so that Dr. Wilcox can review them during your initial consultation as well as avoid repeating tests that have been done recently.

Dr. Wilcox is the only person who will review this information. This information may only be shared or disclosed as detailed in our Notice of Privacy Practices as required by HIPPA. If you have questions, please ask. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the COMMENTS section at the end, or attach it. Copying this questionnaire for your own records may be wise. **PLEASE PRINT CLEARLY.**

Name				Today's Date			
Address		City		State		Zip	
Mobile Phone		Home Phone		Work Phone			
My Primary Phone is ❒ Cell ❒ Home ❒ Work		Email					
Sex ❒ Male ❒ Female		Birth Date		Social Security #			
Weight		Height		Married ❒ Yes ❒ No		Driver's License/State	
In an emergency please notify							
Mobile Phone		Home Phone		Work Phone			
How did you find out about us?							

List all doctors and health professionals you are currently consulting.		
Doctor or Health Professional	Specialty	Phone

Describe your **Single Main Health Issue**. Other issues can be described on the next page.	
If you have been given a diagnosis for this problem, what is it?	
When, specifically, did this problem begin?	
What type of treatment have you tried and was it helpful?	
To what extent does this problem interfere with your activities such as work, exercise, recreation, hobbies, sleep or sex?	

Please list in order of importance the **Other Health Issues** that concern you.			
Health Issue	How often does it occur?	How severe? 1-10, 1 is low	How long have you had it?

List all allergies to prescription and nonprescription drugs.	

List all significant allergies to foods or chemicals.	

Please list all prescriptions medications at the top, followed by nonprescription medications and then healthcare supplements (vitamins, minerals, herbs, etc.) you are currently taking.				
Name	**Reason For Using It**	**How Much?**	**How Often?**	**How Long?**

Ever been on the following for a prolonged time? Print “Current” in the “Age” column if you are currently using them.		
Medication	**Age**	**How Long?**
Antibiotics		
Antacids, heartburn medicines (Tagamet, Zantac, etc.)		
Steroids (Prednisone, Cortisone, Nasal Spray, Cream or Shots)		
Pain Medicines (Narcotic Pain Meds, Acetaminophen, NSAIDs - Ibuprofen, etc.)		
Osteoporosis/osteopenia medicines (Fosamax, Actonel, Boniva, etc.)		
Chemotherapy drugs		
Radiation treatment for cancer		

HEALTH HISTORY CHRONOLOGY CHART

List, in chronological order by age, when each health issue started or a medical condition was diagnosed, hospitalizations, surgeries, biopsies, infections (other than colds or flu unless significant), significant illnesses, significant injuries, immunizations, dental fillings, crowns, root canals, as well as pregnancies, miscarriages and abortions. Please try to be as complete as possible because this information may be critical to unraveling your case. Start at as early an age as possible.

Age	Health Issue

Has your Mother (M), Father (F), Grandmother (GM), Grandfather (GF), Sister (S), Brother (B), Aunt (A) or Uncle (U) had any of the following? Put the appropriate letters (M, F, GM, GF, S, B, A, U) beside any checked box.		
❒ Heart attack	❒ Skin cancer	❒ Osteoarthritis
❒ Heart disease	❒ Lung cancer	❒ Rheumatoid Arthritis
❒ Congestive heart disease	❒ Cancer, other	❒ Autoimmune disease
❒ Stroke	❒ Asthma	❒ Osteoporosis
❒ High blood pressure	❒ COPD	❒ Alzheimer's, Dementia
❒ Diabetes	❒ Emphysema	❒ Parkinson's, Tremors
❒ Breast cancer	❒ Lung disease, other	❒ Psychological problems
❒ Ovarian cancer	❒ Liver disease	❒ Alcohol addiction
❒ Colorectal cancer	❒ Nephritis	❒ Drug addiction
❒ Prostate cancer	❒ Kidney disease, other	
Describe other health problems of note in your family?		
Describe any genetic problems?		

Please check the appropriate box if you have recently or currently had problems with any of the following. If any of the problems was a major concern in the past, check the box and write the year it was a problem to the right of the problem. Each category is arranged to read from top to bottom and then left to right.

GENERAL		
❒ Anemia	❒ Chronic fatigue syndrome	❒ Recent weight loss
❒ Always fatigued	❒ Perspire easily without exertion	❒ Recent weight gain
❒ Fatigue easily	❒ Perspire with difficulty or not at all	❒ Seldom thirsty
❒ Sudden drop in energy	❒ Often "sick" as a child	❒ Often thirsty
Was your birth unusual? ❒ Prolonged ❒ Forceps ❒ Cesarean ❒ Other (describe)		

GASTROINTESTINAL SYSTEM		
❒ Constipation	❒ Gluten sensitivity	❒ Stomach acidity
❒ Hard stool	❒ Irritable bowel syndrome	❒ Heartburn
❒ Difficulty passing stool	❒ Spastic colon	❒ Indigestion
❒ Bowel movements feel incomplete	❒ Crohn's disease	❒ Gurgling noise in stomach
❒ Frequent laxative use	❒ Colitis or ulcerative colitis	❒ Nausea
❒ Diarrhea	❒ Diverticula	❒ Vomiting
❒ Traveler's diarrhea	❒ Diverticulitis or diverticulosis	❒ Ulcer
❒ Loose stool	❒ Intestinal polyps	❒ Hiatal hernia
❒ Erratic bowel movements	❒ Hemorrhoids	❒ Bad breath
❒ Foul smelling stool	❒ Intestinal gas	❒ Bitter taste in mouth
❒ Undigested food in stool	❒ Flatulence	❒ Gallstones
❒ Blood in stool	❒ Belching	❒ Poor appetite
❒ Black stool	❒ Abdominal bloating	❒ Excessive appetite
❒ Mucus in stool	❒ Abdominal pain or cramping	❒ Food allergies
❒ Celiac disease	❒ Stomach pain or cramping	❒ Parasites
How often do you have a bowel movement?		
Any other problems with your digestive system or bowel movements?		

EARS, NOSE, THROAT, MOUTH & DENTAL		
❒ Congestion in ears	❒ Difficulty swallowing	❒ Frequent dental cavities
❒ Ear infection or earache	❒ Lump or pit in throat	❒ Dentures
❒ Ringing in the ears	❒ Sore throat or strep throat	❒ Metallic taste in mouth
❒ Difficulty hearing	❒ Tonsillitis	❒ Geographic tongue
❒ Deafness	❒ Swollen lymph nodes	❒ Sores on tongue
❒ Head cold	❒ Dry mouth	❒ Center crack in tongue
❒ Nasal congestion	❒ Excessive saliva or drooling	❒ Cracks in tongue
❒ Runny nose	❒ Jaw tension or clicking (TMJ)	❒ Scalloped edges on tongue
❒ Sneezing	❒ Grinding teeth	❒ Pale tongue
❒ Allergies	❒ Gum problems	❒ Red tongue
❒ Sinus congestion or pain	❒ Bleeding gums	❒ Purple or dark tongue
❒ Sinusitis or sinus infection	❒ Sores in mouth	❒ Dry tongue
❒ Nose bleeds	❒ Cold sores/fever blisters (HSV1)	❒ Thin white coat on tongue
❒ Facial pain	❒ Sores around lips	❒ Thick creamy coat on tongue
❒ Decreased sense of smell	❒ Dental infections	❒ Red spots on tongue
If you have root canals, how many and in which teeth?		
Any other problems with your ears, nose, throat, mouth or teeth?		

RESPIRATORY SYSTEM		
❒ Chronic cough	❒ Bronchitis	❒ Shortness of breath
❒ Dry cough	❒ Pneumonia	❒ Wheezing
❒ Tight rattling cough	❒ Pain with deep breath	❒ Asthma – difficult exhaling
❒ Loose productive cough	❒ Tuberculosis	❒ Asthma – difficult inhaling
❒ Cough thick, sticky colored phlegm	❒ Cough up blood	❒ Asthma – worse with exertion
❒ Cough thin, watery clear phlegm	❒ Emphysema	❒ COPD
Any other problems with your lungs or breathing?		

IMMUNE SYSTEM		
❒ Flu	❒ Chills	❒ Cancer
❒ Recurrent fevers	❒ Not breast fed	❒ Hepatitis
❒ Frequent colds		❒ Mononucleosis
If you have a chronic viral, bacterial or fungal infection, what is it?		
If you have an autoimmune problem, what is it?		
Have you recently had any immunizations?		
Any other problems with your immune system?		

SLEEP		
❒ Difficulty falling asleep	❒ Nightmares	❒ Narcolepsy
❒ Shallow sleep	❒ Difficulty waking in morning	❒ Sleep too much
❒ Dream disturbed sleep	❒ Wake up not refreshed	❒ Sleep too little
❒ Wake at night – thinking	❒ Sleepy in the afternoon	❒ Sleep apnea
❒ Wake at night – mind empty	❒ Need to take naps	❒ Snoring
How many hours do you usually sleep in 24 hours?		During what hours do you sleep?
Any other sleep related problems?		

SKIN HAIR & NAILS		
❒ Rashes	❒ Recent change in mole	❒ Lengthwise ridges on nails
❒ Hives	❒ Warts	❒ Crosswise ridges on nails
❒ Itching	❒ Dry skin	❒ White spots on nails
❒ Eczema	❒ Cracked skin on hands	❒ Thick nails
❒ Psoriasis	❒ Cracked skin on feet	❒ Fungus under nails
❒ Shingles (herpes zoster)	❒ Moist palms	❒ Split nails
❒ Herpes virus 1 (HSV1) - oral	❒ Moist feet	❒ Weak, brittle or flaking nails
❒ Pimples or acne	❒ Fungus on skin	❒ Clubbing (convex) nails
❒ Boils	❒ Hair loss	❒ Spooning (thin & concave) nails
❒ Ulcerations or sores	❒ Dandruff	❒ No moons
❒ Infections or inflammations	❒ Dry hair	❒ Large moons
❒ Recent moles	❒ Pale lusterless nails	❒ Nail biting
Any other problems with your skin or hair?		

CARDIOVASCULAR & BLOOD		
❒ Irregular heartbeat/arrhythmia	❒ High blood pressure/hypertension	❒ Cold hands
❒ Heart valve problems (prolapse)	❒ High cholesterol	❒ Cold feet
❒ Rapid heartbeat or palpitations	❒ High triglycerides	❒ Hot hands or palms
❒ Angina, chest pain or pressure	❒ Stroke	❒ Hot feet or soles
❒ Back pain	❒ Blood clots	❒ Generally too cold
❒ Shortness of breath	❒ Phlebitis	❒ Generally too hot
❒ Coronary artery disease	❒ Varicose veins	❒ Rheumatic fever
❒ Heart disease	❒ Hemochromatosis/iron overload	❒ Current smoker
❒ Heart attack/myocardial infarction	❒ Bruise easily	❒ Former smoker
❒ Known heart disease	❒ Hemophilia	❒ Sedentary lifestyle
❒ Known vascular disease	❒ Anemia	❒ Overweight
❒ Heart Surgery	❒ Edema	❒ Diabetes
❒ Family history of heart disease	❒ Swelling of hands or arms	❒ Low blood pressure
❒ Post menopausal	❒ Swelling of feet or legs	❒ Blackouts or fainting
❒ High cholesterol	❒ Low cholesterol	❒ High Triglycerides
What is your blood type? ❒ A pos. ❒ A neg. ❒ AB pos. ❒ AB neg. ❒ B pos. ❒ B neg. ❒ O pos. ❒ O neg.		
If you have ever had a blood transfusion, when?		

MUSCULOSKELATAL SYSTEM		
❒ Neck pain or stiffness	❒ Scoliosis	❒ Foot or toe pain or stiffness
❒ Shoulder blade pain	❒ Sacroiliac pain or stiffness	❒ Numbness or tingling in feet
❒ Shoulder joint pain or stiffness	❒ Hip joint pain or stiffness	❒ Muscle spasms or cramps
❒ Rotator cuff tear or syndrome	❒ Pain into thigh or upper leg	❒ Muscle weakness
❒ Upper arm pain or stiffness	❒ Pain into calf or lower leg	❒ Paralysis
❒ Elbow pain or stiffness	❒ Weak legs	❒ Stiff all over
❒ Wrist pain or stiffness	❒ Knee pain or stiffness	❒ Osteoarthritis
❒ Carpal tunnel syndrome	❒ Weak knees	❒ Rheumatoid arthritis
❒ Numbness or tingling in hands	❒ Leg or calf cramping	❒ Osteopenia
❒ Hand or finger pain or stiffness	❒ Restless leg syndrome	❒ Osteoporosis
❒ Upper back pain or stiffness	❒ Ankle pain or stiffness	❒ Tendonitis
❒ Mid back pain or stiffness	❒ Weak ankles	❒ Fibromyalgia
❒ Low back pain or stiffness		
If you have pain, where is it located?		
Is the problem helped by ❒ pressure ❒ heat ❒ cold ❒ dry weather ❒ hot weather ❒ other		
Is the problem aggravated by ❒ pressure ❒ heat ❒ cold ❒ damp weather ❒ windy weather ❒ other		

NEUROLOGICAL SYSTEM & HEAD		
❒ Dizziness or loss of balance	❒ Parkinson's	❒ Migraine headache
❒ Seizures or epilepsy	❒ Multiple sclerosis	❒ Cluster headache
❒ Alzheimer's	❒ Lack of reflex	❒ Headache
❒ Dementia	❒ Unusual lack of coordination	❒ Concussion
If you have numbness, tingling or abnormal sensation, where is it?		
Any other problems with your head or neurological system?		

EYES		
❒ Nearsighted (myopia)	❒ Sensitivity to light	❒ Watery eyes
❒ Farsighted (hyperopia)	❒ Blurred vision	❒ Itchy eyes
❒ Astigmatism	❒ Floating spots	❒ Red eyes
❒ Glaucoma	❒ Pressure behind eyes	❒ Conjunctivitis
❒ Cataracts	❒ Eye pain	❒ Need eyeglasses
❒ Poor night vision	❒ Dry eyes	❒ Blindness
❒ Macular degeneration		❒ Decreased vision
Any other problems with your eyes?		

URINARY SYSTEM		
❒ Scanty or small amount of urine	❒ Persistent urge to urinate	❒ Pain/discomfort in bladder area
❒ Dark urine	❒ Frequent urination	❒ Blood in urine
❒ Strong smelling urine	❒ Difficulty urinating	❒ Bladder infection
❒ Cloudy urine	❒ Decreased flow of urine	❒ Kidney infection
❒ Excessive amount of urine	❒ Flow does not stop quickly	❒ Kidney stones
❒ Clear urine	❒ Dribbling	❒ Kidney disease
❒ Unable to hold urine	❒ Bed wetting	❒ Night sweats
❒ Urgency to urinate	❒ Pain/burning when urinating	
How many times do you urinate in 24 hours?		How many times do you wake at night to urinate?
Any other problems with your urinary system?		

FEMALE SEXUAL SYSTEM, PREGNANCY & GYNECOLOGICAL		
Number of pregnancies	❒ Painful periods	❒ Uterine fibroids or cysts
Number of births	❒ Cramping before start of period	❒ Ovarian cysts
Premature births	❒ Cramping after start of period	❒ PCOS
Miscarriages	❒ Low back ache with period	❒ Breast cysts or lumps
Abortions	❒ Endometriosis	❒ Fibrocystic breasts
Difficult deliveries	❒ Spotting between periods	❒ Pelvic inflammatory disease
Cesarean sections	❒ Missed periods	❒ IUD
Age of children	❒ PMS	❒ Currently use birth control pills
Age at first menses	❒ Premenstrual irritability	❒ Previously used birth control pills
Last period starting date	❒ Premenstrual emotional sensitivity	❒ Infertility
Duration of flow	❒ Premenstrual bloating	❒ Cannot maintain pregnancy
Days between periods	❒ Premenstrual fluid retention	❒ Trying to become pregnant
Age at start of menopause	❒ Premenstrual headache	❒ Pregnant
❒ Have not begun to menstruate	❒ Premenstrual constipation	❒ Nursing
❒ Hysterectomy	❒ Premenstrual diarrhea	❒ Nausea or morning sickness
❒ Hot flashes	❒ Premenstrual breast sensitivity	❒ Pain/discomfort during intercourse
❒ Irregular cycle	❒ Breast sensitivity during period	❒ Inability to orgasm
❒ Heavy flow	❒ Mid-cycle breast sensitivity	❒ Difficulty achieving orgasm
❒ Light flow	❒ Breast sensitivity	❒ Low sexual energy
❒ Clots	❒ Vaginal discharge	❒ Excessive sexual energy
❒ Dark or brownish blood	❒ Vaginal infection	❒ Sores on genitals
❒ Light colored or pale blood	❒ Abnormal PAP	❒ Herpes simplex virus 2
Any other gynecological or pregnancy problems?		

MALE SEXUAL SYSTEM		
❒ Enlarged prostate	❒ Inability to maintain an erection	❒ Low sexual energy
❒ Prostatitis	❒ Premature ejaculation	❒ Excessive sexual energy
❒ High PSA	❒ Ejaculation during sleep	❒ Priaprism (persistent erection)
❒ Prostate cancer	❒ Inability to achieve orgasm	❒ Swollen testicles
❒ Low sperm count	❒ Pain/discomfort during intercourse	❒ Sores on genitals/ Herpes simplex virus 2
Any other problems with your genitals?		

ENDOCRINE SYSTEM & HORMONES, GENERAL		
❒ Hypothyroid	❒ Low cortisol	❒ Low estrogen
❒ Hashimoto's thyroiditis	❒ Addison's disease	❒ High estrogen
❒ Hyperthyroid	❒ Hyper adrenal function	❒ Low progesterone
❒ Grave's disease	❒ High cortisol	❒ High blood sugar
❒ Goiter	❒ Low DHEA	❒ Diabetes
❒ Wilson's temperature syndrome	❒ Low testosterone	❒ Insulin resistance (Metabolic syndrome)
❒ Adrenal insufficiency		❒ Hypoglycemia
Any other problems with your endocrine system or hormones?		

PSYCHOLOGICAL		
❒ Depression	❒ Hyperactivity	❒ Difficulty handling stress
❒ Lack of motivation	❒ Manic episodes	❒ Indecisiveness
❒ Frequently angry or irritated	❒ Obsessiveness/compulsiveness	❒ Poor memory
❒ Tend to repress emotions	❒ Sadness or grief	❒ Difficulty concentrating
❒ Overly emotional	❒ Frequent crying	❒ Confusion or lack of clarity
❒ Mood swings	❒ Anxiety or fear	❒ Nervous breakdown
❒ Difficulty relaxing	❒ Panic attacks	❒ Suicidal thoughts

For the following area use an "S" for Satisfying, "A" for Acceptable and "P" if it might be a Problem area.

Spouse		Children		Sex Life		Finances		Work		Life In General	

Have you recently had an unusually stressful experience such as divorce, loss of job, severe illness or death?

Is there a constant stress in your life at work, with your family, with your friends?

Generally, how would you rate your stress level? ❒ Low ❒ Moderate ❒ High

Have you ever been attacked or abused? ❒ Physically ❒ Psychologically ❒ Sexually

Any other psychological or emotional concerns?

TOXICITY			
How many mercury amalgam silver fillings do you have now?		How many have you had replaced?	

Have you ever had an unusual exposure to any of the following toxins? ❒ Mercury ❒ Lead ❒ Cadmium ❒ Arsenic

❒ Uranium ❒ Radiation ❒ Radon gas ❒ Pesticides ❒ Herbicides ❒ Toxic Chemicals ❒ Petrochemicals ❒ Other

If you have had an unusual toxic substance exposure, describe what and when?

FOOD & DRINK					
List any food allergies.					
Are you a vegetarian or vegan? Please describe.					
List any dietary restrictions.					
List any strong food cravings.					
Do you salt your food? ❒ Yes ❒ No					
Do you think you might have an eating disorder? ❒ Yes ❒ No					
What kind of water do you drink? ❒ Municipal ❒ Well ❒ Spring ❒ Filtered ❒ Reverse Osmosis ❒ Distilled					
Approximately how many ounces of water do you drink a day?					
Do you drink soft drinks? ❒ Yes ❒ No	How many ounces a day?				

SUBSTANCES					
If you drink alcohol, what do you drink, how much and how often?					
Have you ever had a problem with alcohol or drugs? ❒ Yes ❒ No					
If you smoke or chew tobacco, how much and how often?					
Have you ever smoked or chewed tobacco? ❒ Yes ❒ No	How much?		How long?		
Any other substance issues?					

EXERCISE		
Type of exercise	How long do you exercise?	How often

WORK & TRAVEL	
Describe the work you do, or did if you are retired.	
Where have you traveled outside the U.S.?	

ELECTROMAGNETIC FIELDS (EMF)	
Do you sleep with an electric blanket, electric mattress pad or waterbed heater? ❒ Yes ❒ No	
Do you sleep with a cell phone or electric clock or other electronic device near you? ❒ Yes ❒ No	
Do you leave your Wi-Fi network on during the night? ❒ Yes ❒ No	
Is there a Smart Meter on your home or nearby neighbors home? ❒ Yes ❒ No	
Do you live/work next to a cell tower? ❒ Yes ❒ No	Do you live/work next to high voltage power lines? ❒ Yes ❒ No

GENERAL HEALTH, DIET AND LIFESTYLE

Rate how you feel and function now compared to your “peak” years.			
	No Change	Worse	Much Worse
Energy level	❒	❒	❒
Strength	❒	❒	❒
Exercise endurance	❒	❒	❒
Recovery from exercise	❒	❒	❒
Reaction time	❒	❒	❒
Muscle weakness, stiffness, aching	❒	❒	❒
Joint stiffness, aching	❒	❒	❒
Balance and equilibrium	❒	❒	❒
Steadiness of hand	❒	❒	❒
Memory	❒	❒	❒
Mental quickness	❒	❒	❒
Insomnia	❒	❒	❒
Anxiety	❒	❒	❒
Moodiness	❒	❒	❒
Depression	❒	❒	❒
Digestion	❒	❒	❒
Sexual desire	❒	❒	❒
Sexual function	❒	❒	❒
Vision	❒	❒	❒
Hearing	❒	❒	❒
Height	❒	❒	❒
Weight	❒	❒	❒
Weight control	❒	❒	❒
Water retention	❒	❒	❒
Skin quality	❒	❒	❒

COMMENTS

Use the following space to add anything else you think might be important for the doctor to know.