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Comprehensive Patient Health History Questionnaire

Holistic and preventative medicine is best accomplished when the doctor has a thorough understanding of the patient's physical, mental and emotional condition. The information on this questionnaire will help the doctor understand your needs and how to help you reach your health goals.
Please print all information and put a question mark by anything that you don't understand.
Thank you for taking the time and effort to complete this form.

What are your most important health concerns? List as many as you can in order of importance.

- 1) _____
- 2) _____
- 3) _____

When did you last go to the doctor's office, medical clinic or hospital? What was the reason?

Childhood immunizations and vaccines

Polio	Yes	No	Diphtheria	Yes	No	Tetanus shot	Yes	No
Pertussis	Yes	No	Measles/Mumps/Rubella	Yes	No			
Other	_____							

Hospitalizations and/or Surgeries? _____

Allergies

Do you have any reaction to foods, drugs or other allergens in your environment (cats, mold, dust)?
Yes _____ No _____ If yes, please explain. _____

Current Medications

Please list any prescription medications, over-the-counter drugs, vitamins, minerals, herbs and other supplements that you are taking at this time and how much of these with doses.

- 1) _____ 2) _____ 3) _____

Were there any problems during pregnancy or birth (ie drug or alcohol addition, severe stress, premature birth, C-section etc.) ? _____

Weight and Height? _____

Review of Symptoms

Check line if any symptoms are current or in the past noteworthy

SKIN & NECK

Rashes _____
Swollen Glands _____

Eczema, Hives _____
Night Sweats _____

RESPIRATORY

Cough _____
Asthma _____
Difficulty breathing _____

Spitting up blood _____
Pneumonia _____
Bronchitis _____

EYES

Impaired vision _____
Plugged Tear duct _____

Glasses / Contacts _____

CARDIOVASCULAR

High blood pressure _____

Murmurs _____

EARS

Impaired hearing _____
Dizziness _____

ringing _____
Earache _____

GASTROINTESTINAL

Trouble Swallowing _____
Nausea _____
Vomiting blood _____
Bowel Movements how often ? _____

Reflux _____
Vomiting _____
Burping or gas? _____
Is this a change? _____

NOSE and SINUS

Frequent colds _____
Hay fever _____

Stiffness _____
Sinus problems _____

MOUTH and THROAT

Frequent sore throat _____

Gum problems _____

URINARY

Pain on urination _____

Frequent infections _____

FEMALE REPRODUCTIVE

Age menses began _____
Bleeding between periods _____

Average number of days _____
Painful menses _____

MALE REPRODUCTIVE

Circumcised ? _____

Descended Testes _____

SLEEP

How long does child sleep in the night? _____
Does your child nap and for how long? _____

How often does child wake up? _____

Does anyone in the household Smoke? _____
Pets? How Many? _____

New Construction in the home? _____

Mold in home? _____

Do you read bedtime stories to your child? _____
Does your family eat meals together? _____

Foreign Travel? _____
TV/Computer use – How long? _____