Transformational Health
transform your life

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PATIENT HEALTH QUESTIONNAIRE

If you would like a soft copy of this questionnaire, please email drsedmak@transformational-health.com. If you have any questions, you can call (425) 996-8600 or email drsedmak@transformational-health.com.

Date: _____

Patient Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender:_____

Occupation/Employer: _____ SSN: _____

Marital Status: _____

Phone numbers: Home _____ Work _____

Mobile _____ Other _____

Email: _____

At which places may we leave messages? _____

Emergency contact: _____ Phone: _____

Relationship to you: _____

PRIVACY PRACTICES

I have read and understand the privacy practices of Transformational Health. Please see "Notice of Privacy Practices" and sign and date here:

Signature: _____ Date: _____

Name: _____ Date: _____

HEALTH HISTORY

Please use separate pages if you need more room to write

What are your most important health problems? (symptoms, diagnosis, duration, etc.; use extra pages if necessary)

1. _____
2. _____

Prescription and over-the-counter medications (Use extra pages if necessary)

Name	**Dose**
_____	_____
_____	_____
_____	_____

Vitamins, supplements, herbs, homeopathics, other alternative remedies (Use extra pages if necessary)

Name	**Dose**
_____	_____
_____	_____
_____	_____

Conditions with which you have been diagnosed: _____

_____

Allergies to medications, foods, other substances: _____

_____

Diet: Please enter number or amount per day

Meals: _____ Snacks: _____ Caffeinated drinks: _____ Alcoholic drinks: _____

Water: _____ Other drinks: _____ Tobacco use: _____

Name: _____ Date: _____

Accidents or Significant Traumas (physical or emotional, use extra pages if necessary)

Description **Date**

_____ _____

_____ _____

Surgeries, Hospitalizations, and/or In-patient Treatments (use extra pages if necessary)

Description **Date**

_____ _____

_____ _____

YOUR FAMILY MEDICAL HISTORY (Please mark each column that applies)

	Father	Mother	Brother(s)	Sister(s)	Child	Spouse	Other
Age (at death if deceased)							
Cancer							
Diabetes							
Hypoglycemia (low blood sugar)							
Heart Disease							
High Blood Pressure							
Stroke							
Glaucoma							
Epilepsy							
Mental Illness							
Alcohol/Drug Addiction							
Allergies							
Asthma							
Skin problems							
Anemia							
Kidney Disease							
Osteoporosis							
Tuberculosis							
Other							

Anything else you want Dr. Sedmak to know? (use extra pages if necessary)

_____

_____

_____