AmyBurkhart M.D., R.D.
INTEGRATIVE MEDICINE | CELIAC DISEASE, GLUTEN INTOLERANCE AND DIGESTIVE HEALTH

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Health History Questionnaire

Please fill out this confidential questionnaire packet to the best you can so that I may know how to best treat you. Thank you.

—Dr. Amy Burkhart

Name (First, Middle, Last)

Address

City | State | Zip

Home Phone | Work Phone | Email Address

Birthdate | Age | Height | Weight | Sex

Occupation

Primary Care Physician Name | Telephone Number

Address

Referred By | Today's Date

Problem List

What is the primary reason for your visit today? Have you sought treatment for this before? What happened?

Beside the above health concern, list current ongoing problems in order of importance to you.
(#1 = most important)

Problem	Date of Onset	Treatment	Outcome
1.			
2.			
3.			
4.			
5.			

Do you have any disabilities? ❑ Yes ❑ No If yes, please describe:

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Past Medical History

Problem	Currently?	Past?	Notes
Anemia	❑	❑	
Arthritis	❑	❑	
Asthma	❑	❑	
Back Injury	❑	❑	
Bronchitis/Emphysema	❑	❑	
Cancer	❑	❑	
Celiac Disease	❑	❑	
Chronic Fatigue Syndrome	❑	❑	
Crohns or Ulcerative Colitis	❑	❑	
Diabetes	❑	❑	
Epilepsy/Seizures	❑	❑	
Fibromyalgia	❑	❑	
Food Allergies/Intolerances	❑	❑	
Gallstones	❑	❑	
Gluten Intolerance	❑	❑	
Head Injury	❑	❑	
Heart Attack/Angina	❑	❑	
Heart Problems (Other)	❑	❑	
Hepatitis	❑	❑	
High Cholesterol or Triglycerides	❑	❑	
High Blood Pressure	❑	❑	
Irritable Bowel Syndrome	❑	❑	
Kidney Stones	❑	❑	
Neck Injury	❑	❑	
Pneumonia	❑	❑	
Rhuematic Fever	❑	❑	
Sinusitis	❑	❑	
Sleep Apnea	❑	❑	
Thyroid Disease	❑	❑	
Other: _____	❑	❑	
Other: _____	❑	❑	
Other: _____	❑	❑	

Diagnostic Studies

Type	Date	Reason
Appendectomy		
Barium Enema		
Barium Swallow		
Chest X-ray		
Colonoscopy		
CT scan of Abdomen		
CT scan of Brain		
CT scan of Spine		
EKG		
Gall Bladder		
Hernia		
Hysterectomy		
Upper Endoscopy		
Lower GI		
MRI Head		
MRI other		
Surgery		
Tonsillectomy		

Hospitalizations

Where	When	Why

Medication History

Name	Reason	Dose	Date Started

Antibiotic History

How often have you taken antibiotics?

Infancy/Childhood:	❑ Never	❑ Rarely	❑ Often	❑ Very Often
Teen:	❑ Never	❑ Rarely	❑ Often	❑ Very Often
Adulthood:	❑ Never	❑ Rarely	❑ Often	❑ Very Often

Supplement History

Name and Brand	Reason	Dose	Date Started

Medication or Supplement Allergies

Allergen/Trigger	Reaction

Other Allergies—Food, Environmental, etc.

Allergen/Trigger	Reaction

Social

With whom do you live? Please include ages.

Do you have any regular hobbies? How often and with whom do you do them?

Have you lived or traveled outside of the USA? If so, when and where?

Do you have any pets or farm animals? If yes, what are they and where do they live (indoors, outdoors, both)?

Have you or your family recently had any life changes/stressors? If yes, please describe.

Have you experienced any major losses in life? If yes, please describe.

Do you belong to a group or community? If yes, please describe.

Do you have enough money to meet your needs? ❑ Yes ❑ No

Emotional/Spiritual

What are the major stressors in your life?

On a scale of 1–10, how would you rate your stress in the past month? Please circle a number.

(Relaxed) 1 2 3 4 5 6 7 8 9 10 (Completely Stressed)

Do you consider yourself a spiritual person? Why?

Do you practice an organized religion? If yes, which one?

Do you attend spiritual/religious services or gatherings? If yes, how often?

How important is spirituality/religion to you and your family?

❑ Not important ❑ Somewhat important ❑ Very important

Mood

Have you ever had treatment for or been told you have emotional issues? (i.e. depression, anxiety, anger, panic attacks, phobias) If yes, please explain.

Are there any significant traumas (emotional or physical) that have affected you? If yes, please explain.

Over the past month, how often have you . . .	**None or little of the time**	**Some of the time**	**Most of the time**	**All of the time**
1. been feeling low in energy or slowed down?	❑	❑	❑	❑
2. been blaming yourself for things?	❑	❑	❑	❑
3. had poor appetite?	❑	❑	❑	❑
4. had difficulty falling asleep or staying asleep?	❑	❑	❑	❑
5. been feeling hopeless about the future?	❑	❑	❑	❑
6. been feeling blue?	❑	❑	❑	❑
7. been feeling no interest in things?	❑	❑	❑	❑
8. had feelings of worthlessness?	❑	❑	❑	❑
9. thought about or wanted to commit suicide?	❑	❑	❑	❑
10. had difficulty concentrating or making decisions?	❑	❑	❑	❑

Physical Activity

How often do you exercise? How many minutes each time?

What type of exercise/physical activity do you do?

How important is exercise to you?

❑ Not important ❑ Somewhat important ❑ Very important

Environmental

Are you exposed to smoke at home? ❑ Yes ❑ No

Are you exposed to smoke at work? ❑ Yes ❑ No

Do you live near agricultural land or chemical plants? ❑ Yes ❑ No

Do you have any other significant environmetal exposures? ❑ Yes ❑ No If yes, please explain.

Work History

What is your current occupation? How long have you had this occupation?

Please list your previous jobs:

How much time have you lost from school or work in the past year?

❑ 0–6 days ❑ 1–2 weeks ❑ More than 2 weeks

If you have lost more than 2 weeks from school or work in the past year, please explain.

Relaxation

What do you do to relax?

Please mark the boxes below where appropriate.

Relaxation Technique	Never tried	Use currently	Not for me	Interested in
Biofeedback	❑	❑	❑	❑
Breathing exercises	❑	❑	❑	❑
Hypnosis	❑	❑	❑	❑
Massage/body work	❑	❑	❑	❑
Meditation	❑	❑	❑	❑
Progressive muscle relaxation	❑	❑	❑	❑
Tai Chi/Qi Gong	❑	❑	❑	❑
Visualization/guided imagery	❑	❑	❑	❑
Yoga	❑	❑	❑	❑
Other:_____	❑	❑	❑	❑

Energy

On a scale of 1–10, how would you rate your overall energy? Please circle a number.

(Low Energy) 1 2 3 4 5 6 7 8 9 10 (High Energy)

Sleep

How many hours do you sleep each night?_____

Do you wake up rested? ❑ Yes ❑ No

Do you wake up during the night? ❑ Yes ❑ No

Do you have difficulty falling asleep? ❑ Yes ❑ No

Do you snore? ❑ Yes ❑ No

Habits

Do you smoke? How much? For how many years?

Would you like to quit? ❑ Yes ❑ No

Do you drink alcohol (i.e. beer, wine, liquor)? ❑ Yes ❑ No

How often do you drink alcohol?

❑ None ❑ Twice a week ❑ 3–5 times a week ❑ Daily

Does anyone in your family have a problem with drugs or alcohol? ❑ Yes ❑ No

When you drink, you typically have:

❑ 1 drink ❑ 2 drinks ❑ 3 drinks ❑ More than 3 drinks

Do you drink caffeine daily (i.e. cola, coffee, tea)? ❑ Yes ❑ No How many per day?_____

Do you currently use drugs (i.e. pot, cocaine, crack, heroin, speed) ❑ Yes ❑ No

If yes, please describe the type of drugs and how often you use them.

History with Alternative or Complementary Therapies

Method	Never tried, not familiar	Use currently	Not for me	Interested in
Acupuncture	❑	❑	❑	❑
Chiropractic	❑	❑	❑	❑
Energy Medicine (i.e. Reiki, healing touch, etc.)	❑	❑	❑	❑
Herbs	❑	❑	❑	❑
Homeopathy	❑	❑	❑	❑
Massage	❑	❑	❑	❑
Mind body (i.e. hypnotherapy, meditation, biofeedback)	❑	❑	❑	❑
NAET	❑	❑	❑	❑
Nutrition	❑	❑	❑	❑
Osteopathy	❑	❑	❑	❑
Other:_____	❑	❑	❑	❑

Childhood History

Birth History:

❑ Full term ❑ Premature How many weeks premature?_____

❑ Bottle fed ❑ Breast fed Breast fed for how long?_____

How would you rate your health as a child? ❑ Good ❑ Fair ❑ Poor

List any serious childhood illnesses:

_____

_____

_____

Women's Health History

Last Menstrual Period:_____

Are your cycles regular? ❑ Yes ❑ No Duration?_____

Any difficulty with your periods? ❑ Yes ❑ No

Any recent changes in your cycle? ❑ Yes ❑ No

Any history of reproductive problems? ❑ Yes ❑ No

Number of pregnancies:_____

Number of live births:_____

Have you ever had a bone density study? ❑ Yes ❑ No If yes, write date of study:_____

Date of last mammogram:_____

Family History

Family history of cancer? ❑ Yes ❑ No If yes, which type?_____

Family history of autoimmune disease? ❑ Yes ❑ No If yes, which type?_____

Family history of celiac disease? ❑ Yes ❑ No If yes, who?_____

Family history of gluten intolerance? ❑ Yes ❑ No If yes, who?_____

Are there any other medical conditions that run in your family? ❑ Yes ❑ No

Problem	Family Member	Age

Nutrition and Digestive History

Your current weight: _____ height: _____

How much did you weigh 5 years ago?_____lbs.

How much did you weigh when you were 21?_____lbs.

In the last year, have you experienced significant weight loss or gain? ❑ Yes ❑ No

If yes, please describe:_____

_____

List all the foods you have eaten in the last 24 hours, including snacks and beverages:

Breakfast	Foods/Beverage:	Amount:	How prepared?	Where eaten?	At what time?
Lunch	Foods/Beverage:	Amount:	How prepared?	Where eaten?	At what time?
Dinner	Foods/Beverage:	Amount:	How prepared?	Where eaten?	At what time?
Snacks	Foods/Beverage:	Amount:	How prepared?	Where eaten?	At what time?

Nutrition and Digestive History (continued)

Is the chart on the previous page represent a typical day for you? ❑ Yes ❑ No If not, how is it different?

Who usually prepares your meals?

Do you usually eat alone or with someone?

What percentage of meat, eggs, poultry, fruits and vegetables you eat are organic? %

Do you have any symptoms immediately after eating such as bloating, hives, belching? ❑ Yes ❑ No

Do those symptoms occur with a particular food? ❑ Yes ❑ No

If so, what food or type of food is it (i.e. fat, carbohydrate, protein)?

Do you have delayed symptoms with certain foods (i.e. several hours to 24 hours later) such as fatigue, muscle aches, sinus congestion? ❑ Yes ❑ No

What happens when you skip a meal?

Do you crave particular foods? ❑ Yes ❑ No

Do you have an aversion to particular foods? ❑ Yes ❑ No

Do you salt your food? ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑ No If yes, why?

If yes, please mark the special diet you are on:

❑ Gluten Free	❑ Blood Type Diet	❑ Elimination Diet
❑ Dairy Free	❑ FODMAPS Diet	❑ Candida Diet
❑ Diabetic	❑ Specific Carbohydrate Diet	❑ Body Ecology Diet
❑ Vegetarian	❑ Anti-Inflammatory Diet	❑ Paleo Diet
❑ Vegan	❑ GAPS Diet	❑ Other:

Is there any other thing about your diet I should know? If yes, please describe.

Nutrition and Digestive History (continued)

If you have any of the following symptoms please circle how often they occur.

Symptom	Rarely	Sometimes	Often	Frequently/Always
Burping	❑	❑	❑	❑
Bloating	❑	❑	❑	❑
History of Constipation	❑	❑	❑	❑
Iron Deficiency Anemia	❑	❑	❑	❑
Food Allergies/Sensitivities	❑	❑	❑	❑
Fullness after meals	❑	❑	❑	❑
Nausea after supplements	❑	❑	❑	❑
Stomach upsets easily	❑	❑	❑	❑
Poor Appetite	❑	❑	❑	❑
Sour Taste in Mouth	❑	❑	❑	❑
Nighttime Coughing	❑	❑	❑	❑
Nighttime sweating	❑	❑	❑	❑
Heartburn	❑	❑	❑	❑
Difficulty swallowing liquids or solids	❑	❑	❑	❑
Shortness of breath after eating	❑	❑	❑	❑
Abdominal cramping	❑	❑	❑	❑
Indigestion 1–3 hours after eating	❑	❑	❑	❑
Fatigue after eating	❑	❑	❑	❑
Excessive gas/flatulence	❑	❑	❑	❑
Alternating constipation/diarrhea	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑
Fiber causes constipation	❑	❑	❑	❑
Mucous in stools	❑	❑	❑	❑
Poorly formed stools	❑	❑	❑	❑
Shiny stool	❑	❑	❑	❑
More than 3 bowel movement per day	❑	❑	❑	❑
Dry skin	❑	❑	❑	❑
Brittle Hair	❑	❑	❑	❑
Pain in left side under rib cage or chronic stomach pain	❑	❑	❑	❑
Acne	❑	❑	❑	❑
Food Allergies	❑	❑	❑	❑
Difficulty gaining weight	❑	❑	❑	❑

Nutrition and Digestive History (continued)

If you have any of the following symptoms please circle how often they occur.

Symptom	Rarely	Sometimes	Often	Frequently/Always
Foul smelling stool	❑	❑	❑	❑
Gallbladder problems or history of gallbladder problems	❑	❑	❑	❑
Undigested food in stool	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Reflux/Heartburn	❑	❑	❑	❑
History of alcoholism	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑
Excessive bloating with sugar, fiber or carbohydrate intake	❑	❑	❑	❑
Irritable bowel syndrome	❑	❑	❑	❑
Fibromyalgia	❑	❑	❑	❑
Restless Leg Syndrome	❑	❑	❑	❑
Intolerance to probiotics	❑	❑	❑	❑
Are taking antacids or proton pump inhibitors	❑	❑	❑	❑
Joint pain, swelling or arthritis	❑	❑	❑	❑
Chronic tiredness	❑	❑	❑	❑
Sinus or nasal congestion	❑	❑	❑	❑
Chronic or frequent inflammation	❑	❑	❑	❑
Eczema, skin rashes, hives	❑	❑	❑	❑
Asthma, hayfever, airborne allergies	❑	❑	❑	❑
Confusion poor memory or mood swings	❑	❑	❑	❑
Use of NSAIDS	❑	❑	❑	❑
Alcohol consumption makes you feel sick	❑	❑	❑	❑
Ulcerative Colitis, Chrohn's or Celiac disease	❑	❑	❑	❑
Headache or migraines	❑	❑	❑	❑
Chronic Nasal Congestion	❑	❑	❑	❑
Depression/Anxiety or Mood Swings	❑	❑	❑	❑
Menstrual Problems	❑	❑	❑	❑
Infertility	❑	❑	❑	❑
Thyroid Problems	❑	❑	❑	❑
Osteoporosis or Osteopenia	❑	❑	❑	❑
Brain Fog	❑	❑	❑	❑
Get infections easily	❑	❑	❑	❑

Conclusion

What statement most accurately describes your approach to your health?

Is there anything else you would like to tell me about your health or any other concerns you may have?

Please reiterate your goals for this visit: