Integrated Wellness & Health Balance Center
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Precision Health Questionnaire

Welcome to your healthy future! This is designed to help you, the patient, gather as much information as you can about your personal medical history, family history, and lifestyle, all which provide invaluable background data. This is the start of owning your own record.

List all current medications (prescription and/or over the counter) you take, including dosage and frequency, and the reason why you are taking them.

List all current supplements (vitamins, herbs, nutritional supplements) you take, including dosage and frequency, and the reason why you are taking them.

List any diagnostic procedures & surgeries you have had. Provide the approximate date, reason for the procedure/surgery, and result.

List any other medical problems.

Specific Medications

Question	Yes	No
Do you use Viagra, Cialis, Levitra, or any other erectile enhancement drugs?	Yes ☐	No ☐
Have they helped you?	Yes ☐	No ☐
Do you use any other medication for sexual function?	Yes ☐	No ☐
Have you ever used testosterone, hCG, DHEA, or HGH?	Yes ☐	No ☐

Sexual Health (Men)

Symptom	Yes	No
Difficulty attaining/maintaining an erection (or insufficient to maintain penetration)	Yes ☐	No ☐
Lack of early morning erections	Yes ☐	No ☐
Lack of desire/enjoyment	Yes ☐	No ☐
Ejaculation causes pain	Yes ☐	No ☐
Premature ejaculation	Yes ☐	No ☐
Sexual drive underactive	Yes ☐	No ☐
Sexual drive overactive	Yes ☐	No ☐
Pain/coldness in penis	Yes ☐	No ☐
Pain/coldness in testicles	Yes ☐	No ☐
Swollen genitals	Yes ☐	No ☐
Genital sores/lesions	Yes ☐	No ☐
Lump or mass in scrotum	Yes ☐	No ☐
Varicose veins on scrotum	Yes ☐	No ☐
Varicocele in testes	Yes ☐	No ☐
Discharge from penis	Yes ☐	No ☐
Past or present rash on penis	Yes ☐	No ☐
Infertility	Yes ☐	No ☐
Low sperm count	Yes ☐	No ☐
Prostatitis (prostate infections)	Yes ☐	No ☐
Hernia	Yes ☐	No ☐
Jock itch	Yes ☐	No ☐
Past or present sexually transmitted disease (specify)	Yes ☐	No ☐
Frequent infections or illnesses	Yes ☐	No ☐
Frequent colds	Yes ☐	No ☐
Change in appetite	Yes ☐	No ☐
Fatigue/weakness/loss of energy	Yes ☐	No ☐
Lumps in neck, armpits, groin, or breast	Yes ☐	No ☐
Broken bone(s) as an adult	Yes ☐	No ☐
Heat/cold intolerance	Yes ☐	No ☐

Sexual Health (Women)

Lack of libido	Yes ☐	No ☐
Fatigue	Yes ☐	No ☐
Poor sleep	Yes ☐	No ☐
Mood swings	Yes ☐	No ☐
Belly fat	Yes ☐	No ☐
Oily skin	Yes ☐	No ☐
Estrogen deficiency (any symptoms below) Early spotting (day 1-9), continuous bleeding, abnormal bleeding, amenorrhea (no menses), or vasomotor symptoms like hot flashes, sweating, or flushing	Yes ☐	No ☐
Estrogen excess (any symptoms below) Painful menses and cramps, hypermenorrhea, breast tenderness (increased size), urinary tract Infections, hypertension	Yes ☐	No ☐

Skin and Hair

Dry/brittle and/or flaky hair	Yes ☐	No ☐
Hair thinning or falling out	Yes ☐	No ☐
Abnormal fingernails	Yes ☐	No ☐
Toe or fingernail fungus	Yes ☐	No ☐
History of skin disorder or skin condition	Yes ☐	No ☐
Dry/brittle skin	Yes ☐	No ☐
Acne	Yes ☐	No ☐
Age spots	Yes ☐	No ☐
Puffy, wrinkled skin	Yes ☐	No ☐
Swelling/edema	Yes ☐	No ☐
Change in skin color	Yes ☐	No ☐
Dark circles under eyes	Yes ☐	No ☐
Bumpy skin on face or back of arms	Yes ☐	No ☐
Spider veins in nose and/or face	Yes ☐	No ☐
Persistent rash/skin allergy	Yes ☐	No ☐
Sores, boils, sties, lumps/lesions	Yes ☐	No ☐
Slow or poor wound healing	Yes ☐	No ☐
Excessive sweating or itching	Yes ☐	No ☐
Flushing or hot flashes	Yes ☐	No ☐
Bruise easily or excessively	Yes ☐	No ☐

Allergies

Seasonal allergies	Yes ☐	No ☐
Food allergies	Yes ☐	No ☐
Latex or other environmental allergies	Yes ☐	No ☐
Are you allergic to any drugs?	Yes ☐	No ☐
Do you break out in hives?	Yes ☐	No ☐

Eyes/Ears/Nose/Throat

Symptom	Yes	No
Facial pain	Yes ☐	No ☐
Change in vision	Yes ☐	No ☐
Use of corrective lenses (glasses or contacts)	Yes ☐	No ☐
Blurred or tunnel vision	Yes ☐	No ☐
Double vision	Yes ☐	No ☐
Eye pain/inflammation	Yes ☐	No ☐
Hearing loss	Yes ☐	No ☐
Ringing in ears	Yes ☐	No ☐
Ear pain	Yes ☐	No ☐
Balance problems	Yes ☐	No ☐
Ear drainage	Yes ☐	No ☐
Ear infections	Yes ☐	No ☐
Nosebleeds	Yes ☐	No ☐
Stuffy nose	Yes ☐	No ☐
Nasal discharge	Yes ☐	No ☐
Nasal/sinus infections	Yes ☐	No ☐
History of nasal/facial injury	Yes ☐	No ☐
Sore or bleeding gums	Yes ☐	No ☐
Canker sores or cold sores	Yes ☐	No ☐
Frequent sore throat/hoarseness	Yes ☐	No ☐
Difficulty swallowing	Yes ☐	No ☐

Neurological

Symptom	Yes	No
Headaches	Yes ☐	No ☐
Faintness	Yes ☐	No ☐
Seizures/convulsions	Yes ☐	No ☐
History of epilepsy	Yes ☐	No ☐
Tremors/spasms	Yes ☐	No ☐
Dizziness	Yes ☐	No ☐
Tingling or numbness	Yes ☐	No ☐
Balance problems	Yes ☐	No ☐
Paralysis	Yes ☐	No ☐
Muscle weakness	Yes ☐	No ☐
Memory problems	Yes ☐	No ☐
Loss of smell or taste	Yes ☐	No ☐
Problems with attention and concentration	Yes ☐	No ☐
History of accident/injury	Yes ☐	No ☐
History of loss of consciousness	Yes ☐	No ☐
History of stroke	Yes ☐	No ☐

Cardiopulmonary

Condition	Yes	No
Pain in the left arm	Yes ☐	No ☐
Chest pain at rest or while walking/running/lifting weights	Yes ☐	No ☐
Pain in chest or sides	Yes ☐	No ☐
Frequent and recurring upper respiratory infections	Yes ☐	No ☐
Fluid retention (e.g. swollen ankles, legs, etc.)	Yes ☐	No ☐
Cannot tolerate much exercise	Yes ☐	No ☐
Difficulty breathing	Yes ☐	No ☐
Chronic lung congestion	Yes ☐	No ☐
Cough with sputum, with pain	Yes ☐	No ☐
Wheezing	Yes ☐	No ☐
History of asthma	Yes ☐	No ☐
Heaviness in legs	Yes ☐	No ☐
Calf muscle cramps while walking	Yes ☐	No ☐
Heart pounds easily	Yes ☐	No ☐
Heart misses beats or has extra beats	Yes ☐	No ☐
Rapid heartbeat, fluttering	Yes ☐	No ☐
Shortness of breath	Yes ☐	No ☐
Heartburn after eating	Yes ☐	No ☐
Exhaustion with minor exertion	Yes ☐	No ☐
Erratic blood pressure	Yes ☐	No ☐
High blood pressure	Yes ☐	No ☐
Low blood pressure	Yes ☐	No ☐
Breathing problems at night	Yes ☐	No ☐
Difficulty lying flat	Yes ☐	No ☐
History of tuberculosis	Yes ☐	No ☐
History of heart attack	Yes ☐	No ☐
History of heart murmur or irregularity	Yes ☐	No ☐
History of pneumonia	Yes ☐	No ☐

Joints/Muscles/Bones

Condition	Yes	No
Joint pain, swelling, or stiffness	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐
Neck/back pain	Yes ☐	No ☐
Limited/decreased range of motion	Yes ☐	No ☐
Muscle tension or spasms	Yes ☐	No ☐
Muscle weakness	Yes ☐	No ☐
Muscle cramps	Yes ☐	No ☐
Muscle pain	Yes ☐	No ☐
History of gout	Yes ☐	No ☐
History of rheumatic disease	Yes ☐	No ☐
History of injury/fractures	Yes ☐	No ☐
Fibromyalgia	Yes ☐	No ☐
Carpal tunnel syndrome	Yes ☐	No ☐
Osteoporosis (decreased bone density)	Yes ☐	No ☐

Metabolic

Certain foods cause ill feelings	Yes ☐	No ☐
Difficulty gaining weight	Yes ☐	No ☐
Difficulty losing weight	Yes ☐	No ☐
Bad breath (no relief by brushing)	Yes ☐	No ☐
Body odor (no relief by washing)	Yes ☐	No ☐
Total blood cholesterol above 200	Yes ☐	No ☐
HDL cholesterol below 50	Yes ☐	No ☐
LDL cholesterol above 130	Yes ☐	No ☐
Swollen (bulging) eyes	Yes ☐	No ☐
History of thyroid disorder	Yes ☐	No ☐
Cold hands and feet	Yes ☐	No ☐
Thinning or loss of outside portion of eyebrow	Yes ☐	No ☐
Gain weight easily	Yes ☐	No ☐
Crave salt or salty foods	Yes ☐	No ☐
Blushing with no apparent cause	Yes ☐	No ☐
Feel tired or weak if meal is missed	Yes ☐	No ☐
Wake up at night craving sweets	Yes ☐	No ☐
Need to drink caffeine to get going	Yes ☐	No ☐
Feel tired 1-3 hours after eating	Yes ☐	No ☐
Feel faint or weak	Yes ☐	No ☐
Night sweats	Yes ☐	No ☐
Increased thirst	Yes ☐	No ☐
Overweight	Yes ☐	No ☐
Crave sweets (but eating them doesn't relieve symptoms)	Yes ☐	No ☐
Weight loss of more than 10 lbs in past 6 months	Yes ☐	No ☐
Weight gain of more than 10 lbs in past 6 months	Yes ☐	No ☐
Weight has fluctuated more than 10 lbs over last 5 years	Yes ☐	No ☐

Vascular

Swelling in the legs	Yes ☐	No ☐
Varicose veins	Yes ☐	No ☐
Coldness/discoloration in legs/feet	Yes ☐	No ☐
History of blood clots	Yes ☐	No ☐
Raynaud's syndrome	Yes ☐	No ☐

Gastrointestinal/Urological Health

Lack of appetite	Yes ☐	No ☐
Excessive appetite	Yes ☐	No ☐
Abdominal pain	Yes ☐	No ☐
Nausea/vomiting	Yes ☐	No ☐
Heartburn/reflux	Yes ☐	No ☐
Difficulty/pain with swallowing	Yes ☐	No ☐
Dependency on antacids	Yes ☐	No ☐
History of ulcers	Yes ☐	No ☐
History of liver disorder	Yes ☐	No ☐
Flatulence (gas) or bloating	Yes ☐	No ☐
Gallbladder problems	Yes ☐	No ☐
Irritable bowel syndrome	Yes ☐	No ☐
Change in bowel habits	Yes ☐	No ☐
Loss of bowel control	Yes ☐	No ☐
Diarrhea	Yes ☐	No ☐
Constipation (hard or effortful bowel movements)	Yes ☐	No ☐
Hemorrhoids	Yes ☐	No ☐
Blood in stool	Yes ☐	No ☐
Change in stool (color/consistency)	Yes ☐	No ☐
Rectal pain	Yes ☐	No ☐
Frequent urination or scant urination/dribbling	Yes ☐	No ☐
Burning during urination	Yes ☐	No ☐
Loss of bladder control (including leaking)	Yes ☐	No ☐
Excessive nighttime urination (# of times)	Yes ☐	No ☐
Blood in urine	Yes ☐	No ☐
Frequent urinary tract infections	Yes ☐	No ☐
Difficulty urinating or initiating stream	Yes ☐	No ☐
Sense of urgency to urinate	Yes ☐	No ☐
Retention – inability to urinate or empty bladder	Yes ☐	No ☐
Excessive/decreased volume	Yes ☐	No ☐
Abnormal color or odor of urine	Yes ☐	No ☐
Kidney stones	Yes ☐	No ☐

Family History

Enter all the health information that you know about your family. In the left column, you'll find a comprehensive list of medical disorders. In the right column, list names, ages, and relationship (father, maternal grandmother, cousin, sister, etc.) of the family members who are suffering from that illness or condition. If you do not know of any family members with that particular illness or condition, write "none".

CONDITION	YOURSELF	FAMILY MEMBER(S)
Heart disease (heart attack, coronary artery disease, congestive heart failure)		
High blood pressure		
Abnormal ECG		
Cancer		
Anemia		
High cholesterol		
Diabetes		
Endocrine gland disorders (thyroid, adrenal, pituitary)		
Weight control programs		
Lung disease (asthma, emphysema, bronchitis)		
Allergies		
Stomach/esophagus disorders (reflux, stricture, ulcers)		
Bowel disease (malabsorption, lactose intolerance, diverticulitis, Crohn's, colitis, irritable bowel syndrome)		
Liver disease (hepatitis, cirrhosis)		
Kidney disease (stones, infection, cysts)		
Bladder disease		
Autoimmune disease (lupus, rheumatoid arthritis)		
Arthritis		
Osteoporosis		
Neurological disorders (stroke, seizures, Parkinson's, Alzheimer's, multiple sclerosis)		
Migraine headaches		
Memory problems		
Sleep apnea/snoring		
Mental health issues (depression, anxiety, psychotic disorders)		
Substance abuse (alcohol, prescription, recreational drugs, tobacco)		
HIV/AIDS		
Other		

Lifestyle

General Information

Marital status	
Do you have children? How many?	
Do you have grandchildren?	
How close are your ties to your family and friends?	
What is your occupation?	
What are your hobbies?	
Do you travel outside the country?	
Do you use a seatbelt?	
Do you have a working smoke detector?	
Do you have a working carbon monoxide detector?	

Sleep

On an average, how many hours of restful sleep do you get per night?	
How many hours of sleep do you think you need?	
Do you suffer from insomnia, hypersomnia, or sleep apnea?	
During the past month, what percent of the time would you say you wake up feeling fresh and fully rested?	
Have there been any major changes in your sleep patterns in the last year?	
Do you find it difficult to get out of bed in the morning?	

Substance Use

How many servings of an alcoholic beverage do you consume in an average week? Include type of alcohol.	
Do you currently use tobacco? If yes, what type, for how long, and have you ever tried to quit?	
Have you ever used any type of tobacco in the past? If yes, what type, for how long, and when did you quit?	

Personal Assessment

The list below contains several traits that describe people. Select the answer which best describes you.

Trait	Definitely not like me	Somewhat like me	Much like me	Very much like me
Have a need to excel in mostly everything	☐	☐	☐	☐
Always rushed or pressed for time	☐	☐	☐	☐
Eat most meals too fast	☐	☐	☐	☐
Hard driven and competitive	☐	☐	☐	☐
Bossy and domineering	☐	☐	☐	☐

When you are very angry or upset about something, rate each response according to the likelihood of having the listed reaction.

Reaction	Not too likely	Somewhat likely	Very likely
Take a few breaths and talk it out	☐	☐	☐
Act like nothing is wrong or that nothing has happened	☐	☐	☐
Blame it on someone else (it's never your fault)	☐	☐	☐
Apologize even if you are right	☐	☐	☐
Take it out on someone else	☐	☐	☐
Talk it out with someone such as a friend or relative	☐	☐	☐
Get it out in the open (off your chest)	☐	☐	☐
Keep it to yourself	☐	☐	☐

On an average workday, please indicate if you generally feel the following. If you are a homemaker, refer to your household duties, if you are unemployed or retired, think back to your last position.

Symptom	Yes	No
Often feel inadequate or unsure of your performance	☐	☐
Often feel "stretched to the max" with your duties	☐	☐
Often feel pressured or very pressed for time	☐	☐
Often feel like work follows you home	☐	☐
In general, do you get upset if you have to wait for something?	☐	☐

Stress Management

Do you consider yourself to be under a great deal of stress? Which of the following methods do you use to relieve tension or stress. Please check beside all that apply.

Listen to music/play music ☐	Smoke cigarettes/pipe ☐	Sleep ☐	Watch television ☐
Cry ☐	Throw things ☐	Meditate ☐	Blow up ☐
Eat ☐	Exercise or walk ☐	Don't think about it ☐	Work/housework ☐
Do nothing ☐	Turn to faith/pray ☐	Take a drug ☐	Go for a drive ☐
Call a friend or relative ☐	Draw/Paint/Hobby ☐	Have an alcoholic drink ☐	Read ☐
Other			

Mind and Emotions

Are you experiencing the listed symptom to a substantial or unusual degree?

SYMPTOM	Yes	No
Rapid mood swings	☐	☐
Impatient, moody, nervous	☐	☐
Lack of mental alertness	☐	☐
Depression	☐	☐
Anxiety/fear	☐	☐
Lack of self-esteem	☐	☐
Difficulty with memory, attention, or concentration	☐	☐
Short attention span	☐	☐
Personality changes	☐	☐
Short temper/anger/irritability	☐	☐
Excessive worrying	☐	☐
Suicidal thoughts	☐	☐
Confusion/poor comprehension	☐	☐
Difficulty making decisions	☐	☐
Restlessness, hyperactivity, or inability to relax	☐	☐
Change in eating habits with depression	☐	☐
Change in eating habits with stress or anxiety	☐	☐
Change in eating habits with family or friends	☐	☐
Apathy/lethargy	☐	☐

Personal Medical History

Provide the most recent date and results for the tests listed below.

Tests	Date	Results
Rectal exam		
Testing for blood in stool		
Prostate exam		
PSA		
Colonoscopy		
Resting ECG		
Stress ECG		
Stress echo		
Nuclear stress		
Chest x-ray		
Eye exam/eye pressures		

Remember, this is the start of owning your own record. You might explore other options like hormones and metabolic questionnaire for precision medicine analysis with your doctor.

Use this space for anything else you'd like to add or if you need more room for previous questions.