

HEALTH QUESTIONNAIRE

**Print and complete form. Bring to appointment, or mail to 5715 Bella Rose Blvd., Suite 100,
Clarkston, MI 48348, or email to: frontdesk@thedowningclinic.com**

Name _____ Age _____ Date _____

1. Do you currently take a multi-vitamin? _____ Yes _____ No
2. Do you know your blood type _____ A _____ AB _____ B _____ O _____ Don't Know
3. Do you take any supplements? *(please check all that apply)*

_____ Vitamin C	_____ B-Complex	_____ CoEnzyme Q10	_____ Magnesium
_____ Vitamin D	_____ Glucosamine	_____ Beta Carotene	_____ Chromium
_____ Vitamin E	_____ Garlic	_____ Calcium	_____ DHEA
_____ L-Carnitine	_____ Ginkgo Biloba	_____ Saw Palmetto	_____ Fiber
_____ Melatonin	_____ Flax Oil	_____ Fish Oil	_____ Other

4. Do you take any prescription drugs?
If so, please list: _____

5. Are you allergic to any medications, foods, or environmental factors that you know of?

6. Which areas of health are a concern to you? *(check all that apply, circle your most pressing issue)*

<u>General Conditions</u> _____ Allergies _____ Asthma _____ Back Pain _____ Bladder Dysfunction _____ Anxiety / Stress / Depression _____ Low Energy / Fibromyalgia _____ Ear / Hearing Problems _____ Kidney Problems or Stones _____ Migraine Headaches _____ Skin Conditions _____ Thyroid _____ Weight Control _____ Memory Loss _____ Hormones _____ Autoimmune	<u>Heart Disease</u> _____ Angina _____ Cholesterol _____ Coronary Artery Disease _____ High Blood Pressure <u>Digestion</u> _____ Constipation _____ Gas _____ Heartburn / Indigestion _____ Ulcers <u>Vision Care</u> _____ Cataracts _____ Macular Degeneration _____ Glaucoma	<u>Women's Health</u> _____ Breast Cancer _____ Hormone Replacement _____ Hot Flashes _____ Menopause _____ Osteoporosis _____ Heavy/Irregular Periods <u>Men's Health</u> _____ Prostate _____ Impotence <u>Degenerative Diseases</u> _____ Alzheimer's Disease _____ Arthritis _____ Diabetes _____ Other _____
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6. Who else lives in your home? *(please check all that apply)*
_____ No Others _____ Spouse / Significant Other _____ Children
7. Have you recently painted or remodeled? _____ Yes _____ No
8. Water System _____ Well _____ City _____ or other, what kind? _____
9. Do you have pets? _____ Yes _____ No If yes, what kind? _____
10. Are you in a house that was built within _____ 1-5 yrs _____ 6-15 yrs _____ 16-25 yrs
11. What type of flooring is in your home? _____ Synthetic _____ Natural _____ How old? _____
12. Do you use lawn chemicals? _____ Yes _____ No