



Health History Questionnaire

Important: Complete this questionnaire as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a major role in diagnosis and treatment. All the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

Date: _____

Patient Information

Patient Name

Sex

Date of Birth (mm/dd/yyyy)

Age

Country

Email Address

Marital Status

Current Occupation

Contact Number

(mention here the contact number of a person)

Contact Number of Family Member

Type of retreat

Cusco Hostal/Hotel Name



Personal Health History

Childhood Illness: Measles Mumps Rubella Chicken Pox Polio
 Rheumatic Fever

Others:

Medical Illnesses:

Illness:	Age at Onset:	Illness:	Age at Onset:
<input type="checkbox"/> Diabetes	<input type="text"/>	<input type="checkbox"/> Osteoarthritis	<input type="text"/>
<input type="checkbox"/> Hypertension	<input type="text"/>	<input type="checkbox"/> Gout	<input type="text"/>
<input type="checkbox"/> Heart disease	<input type="text"/>	<input type="checkbox"/> Epilepsy	<input type="text"/>
<input type="checkbox"/> Asthma	<input type="text"/>	<input type="checkbox"/> Bleeding disorder	<input type="text"/>
<input type="checkbox"/> Cancer	<input type="text"/>	<input type="checkbox"/> Severe infections	<input type="text"/>
<input type="checkbox"/> Genetic defects	<input type="text"/>	<input type="checkbox"/> High blood pressure	<input type="text"/>
<input type="checkbox"/> Venereal disease	<input type="text"/>	<input type="checkbox"/> Surgeries	<input type="text"/>
<input type="checkbox"/> Allergies	<input type="text"/>	<input type="checkbox"/> Others	<input type="text"/>

How much water do you drink daily?

How many caffeinated drinks do you drink per week (coffee, tea, soda)?



Has there been any change in your general health in the past year?

Are you now under a physician's care for a particular problem?

Have you ever had any serious illnesses, operations or hospitalizations? If so please describe

Do you have any cardiovascular disease, including heart attack?

Do you smoke or chew tobacco?

Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?

Are you on a restricted diet? If so please describe

Have you ever had any psychiatric or psychological treatment? If so please describe

Are you currently in therapy or do you participate in any kind of support group?



Do you practice meditation, yoga, reiki, bioenergy or any other form of self-exploration? If so, please describe

How do you know about us?

Medications:

List all prescription and over the counter medication, herbs and vitamins that you have been taking on a regular basis in the last 3 months.

Name / Frequency

Name / Frequency

Name / Frequency

Allergies:

List name of medicine or food that have resulted in an unfavorable reaction. State reaction.

Medications:

Food:



Surgeries:

Have you ever had any surgeries?

Please explain:

Family Health History

Do any of your family member suffer from high blood pressure problem? (This question is asked to know high BP history of family)

Do any of your family member suffer from diabetes? (This question is asked to know diabetes history of family members)

Is there any specific piece of medical related information which you would like to add? (This question is asked to take any additional information)

Are there people in your family with a history of psychiatric disorders?



Have you ever used any type of drugs? If so please describe

How long ago?

- Marijuana/Cannabis..... Yes No
- Mushrooms..... Yes No
- Nicotine..... Yes No
- Alcohol..... Yes No
- Anphetamines..... Yes No
- Valium..... Yes No
- Cocaine..... Yes No
- Heroine..... Yes No
- Mezcaline..... Yes No
- Crack..... Yes No
- Ketamine..... Yes No
- Ecstasy (MDMA)..... Yes No
- LSD..... Yes No
- Others:

For women only:

Are you pregnant, or is there any chance you might be pregnant? If so you are not able to participate in the Ayahuasca ceremony.

- Yes No
-



Regular menstrual cycle?

Yes No

Describe:

-
- What are your goals for the Ayahuasca retreat?

I understand the importance of a truthful and complete health history to assist to The Healing Tree Center in providing the best care possible.

Patient Signature: _____
