



Lifelogy is a holistic treatment that looks into all aspects of the body health and efficiency of the body working together as a whole. To provide the best treatment we will require comprehensive information about every patient's medical, personal, and family history, along with lifestyle factors. Below is a health questionnaire that is needed in order to pursue our understanding of each individual unique health condition.

Full Name:

Date of Birth:

Age:

Gender

Address

Phone Number:

Email:

Emergency Contact Name:

Emergency Contact Phone:

Reason for Visit: Primary concern or reason for seeking holistic care today:

How long have you been experiencing this issue?

Medical History

Do you have any of the following chronic conditions? (Please check all that apply)

- | | |
|---|---|
| - ☐ Hypertension (high blood pressure) | - ☐ Kidney disease |
| - ☐ Diabetes (Type 1 / Type 2) | - ☐ Liver disease |
| - ☐ Asthma | - ☐ Respiratory disorders (COPD, etc.) |
| - ☐ Heart disease | - ☐ Seizures |
| - ☐ Stroke | - ☐ Depression / Anxiety |
| - ☐ Arthritis | - ☐ Sleep apnea |
| - ☐ Chronic pain (back, joints, etc.) | - ☐ Chronic ear infections |
| - ☐ Chronic Sinusitis | - ☐ Chronic UTI (Urinary Tract Infections) |

Cancer (please specify type):

Other (please specify):

Have you ever been hospitalised?

- ☐ Yes
- ☐ No

If yes, please list the reason(s) for hospitalisation and date(s):

Have you ever had surgery?

(Indicate all medical or beauty surgery)

- ☐ Yes
- ☐ No

If yes, please list type of surgery and date(s):

Do you have any allergies?

- ☐ Yes
- ☐ No

If yes, please list:

Are you currently taking any medications?

- ☐ Yes
- ☐ No

If yes, please list all medications, including dosage:

Do you use any over-the-counter medications or supplements?

- ☐ Yes
☐ No

If yes, please list:

Do you have a history of mental health conditions?

- ☐ Yes
☐ No

If yes, please list:

Family Medical History

Has anyone in your family had the following conditions? (Please check all that apply)

- | | |
|---|--|
| ☐ Heart disease | ☐ Kidney disease |
| ☐ Stroke | ☐ Mental health disorders (anxiety, depression, etc.) |
| ☐ Hypertension (high blood pressure) | ☐ Autoimmune disorders |
| ☐ Diabetes | ☐ Genetic disorders |

Cancer (please specify type):

Other (please specify):

In the last Three Years have you taken antibiotics?

- ☐ Yes
☐ No

If Yes, Please indicate period and dosage of the antibiotics:

Lifestyle and Social History

Do you smoke?

- ☐ Yes
☐ No

If yes, how many cigarettes per day?

Have you ever tried to quit?

- ☐ Yes
☐ No

How many years have you been smoking?

Do you drink alcohol?

- ☐ Yes
☐ No

If yes, how often?

Do you drink coffee, tea or fizzy juice?

- ☐ Yes
☐ No

If yes, please specify:

What is your current employment status?

- ☐ Employed full-time
☐ Employed part-time
☐ Student
☐ Unemployed
☐ Retired

Other (please specify):

Do you exercise regularly?

- ☐ Yes
☐ No

If yes, how often and what type of exercise?

Diet and Nutrition

Do you follow a specific diet (e.g., vegetarian, vegan, low-carb, etc.)?

- ☐ Yes
☐ No

How would you describe your general a typical day of what your diet Looks Like? (e.g., breackfast,lunch, dinner, snacks)

Do you have any dietary restrictions?

- ☐ Yes
☐ No

If yes, please specify:

Do you have desserts Daily

- ☐ Yes
☐ No

If yes, how many times a day?

List examples

Do you take any Probiotics?

- ☐ Yes
☐ No

If yes, what is the strength , how long ?

Do you take any vitamins?

- ☐ Yes
☐ No

What are the dosages? How long?

Reproductive Health (for women)

Are you currently pregnant?

- ☐ Yes
☐ No

If yes, how far along are you?

Do you use contraception?

- ☐ Yes
☐ No

If yes, what method?

Date of last menstrual period:

Any history of abnormal pap smears or gynecological issues?

- ☐ Yes
☐ No

If yes, please specify:

Indicate how many times you pass Stool per day

- ☐ Once a Day
- ☐ More than Once a Day
- ☐ Once every 2 days
- ☐ Once every 3 days
- ☐ Once more than 3 days

What is the texture of you stool usually

How much water a day do you drink?

How many times a day do you pass Urine?

What color is your Urine usually

Preventative Care and Screening

Date of last physical exam:

Date of last mammogram (if applicable):

Date of last blood work:

Date of last colonoscopy (if applicable):

Do you have regular screenings for cholesterol, blood pressure, or diabetes?

- ☐ Yes
☐ No

When was your last screening?

Current Symptoms and Concerns

Have you experienced any of the following symptoms recently?

- ☐ Fever or chills
- ☐ Fatigue
- ☐ Unexplained weight loss or gain
- ☐ Headaches
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Swelling or puffiness
- ☐ Changes in bowel or bladder habits
- ☐ Cough or wheezing

Pain (location and type):

Other concerns (please describe):

Is there anything else you would like your healthcare provider to know?