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	
Relationship Status	
Current Occupation	
Contact Number	
Name & Contact Number of Family Member (mention here the name & contact number of a person for emergencies)	
Cusco Hostel/Hotel Address	
Type of Retreat	

Personal Health History

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Polio

☐ Rheumatic Fever

Others: _____

_____

Medical Illnesses:

Illness:	Age at Onset:	Illness:	Age at Onset:
☐ Diabetes		☐ Osteoarthritis	
☐ Hypertension		☐ Gout	
☐ Heart disease		☐ Epilepsy	
☐ Asthma		☐ Bleeding disorder	
☐ Cancer		☐ Severe infections	
☐ Genetic defects		☐ Bipolar	
☐ Venereal disease		☐ Surgeries	
☐ Allergies		☐ Others	

For Ayahuasca Retreats Only

Name of the Medical Doctor / Specialist listed on your recent Medical Certificate of Health and Wellness (e.g. a doctor's fit note) proving you have completed a recent medical evaluation and exam:

_____

Date of your recent medical evaluation and exam: _____

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 suffer from high blood pressure problem?

Do you suffer from Low blood pressure problem?

Digestion: Please mark below which applies

Quick ( ) Slow ( ) Normal ( )

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 diagnostic? 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 is 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, and the date last taken.

Name	Frequency	Date

Allergies:

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

Medications:

Food:

Surgeries & Accidents:

Have you ever had any surgeries or accidents?

Please explain:

Traumas / Abuse:

Have you ever had any traumas or physical or emotional abuse?

Please explain:

Please note that you may choose to discuss this question in a private conversation with Healing Tree Center Staff instead

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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 low blood pressure problem? (This question is asked to know low BP history of family)

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

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

Are your parents still alive? Yes: ☐ No: ☐

How was your relationship with them in the past?

How is your relationship with them now?

Do you have siblings (Half/Step/Full)? Yes: ☐ No: ☐

If yes, how many of each? Brothers: ☐ Sisters: ☐

How was/ is your relationship with them in the past, and now?

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

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:

Birth control: If so please describe type.

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: _____