Health Questionnaire

Please complete this questionnaire carefully. All information will be held in absolute confidence.

Name ____________________ Date ____________________

Address ____________________ Social Security Number ____________________

____________________ Date of Birth ____________ Age ______

Phone - Home ____________________ Phone - Work____________________

Employer ____________________ Height __________ Weight __________

Occupation ____________________ Marital Status ____________________

Email address ____________________ Referred by ____________________

Emergency contact ____________________ Emergency phone ____________________

Main Problem(s)____

____

Does this problem interfere with daily activities? Please explain. ____________________

____

Have you been given a diagnosis for this problem?____________________

____

Personal History: (check all that apply, note history & treatment)

( ) Cancer
( ) Diabetes
( ) Hepatitis
( ) Heart Disease
( ) Sexually Transmitted Disease
( ) High Blood Pressure
( ) Thyroid Disease
( ) Seizures
( ) Other

Family Medical History (Please identify the family member's relation to you)

( ) Cancer
( ) Diabetes
( ) Allergies
( ) Heart Disease
( ) Asthma
( ) High Blood Pressure
( ) Stroke
( ) Seizures
( ) Other

Surgeries: (Please include date) ____

____

Significant Trauma: (Describe accidents, falls…with dates, treatment, & results) ____________________

____

____

____

Medicines taken within the last two months (including vitamins, drugs, herbs…) ____________________

____

Allergies: (Causes, symptoms, discomforts) ____

____

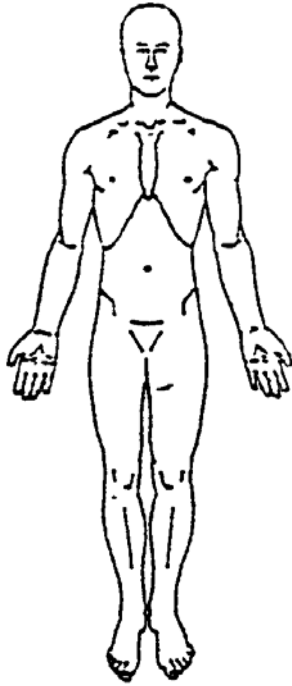
____

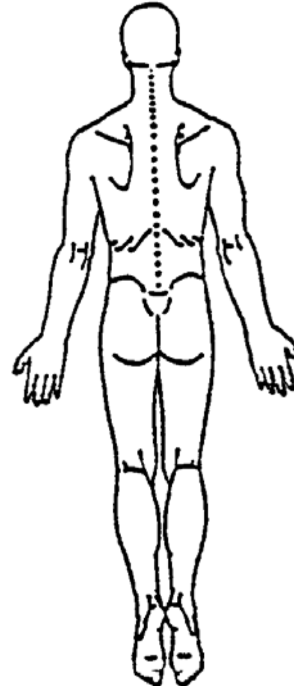
How many cigarettes do you smoke a day? ______________

How much coffee, tea, or cola do you drink a day? ____________________

How much alcohol do you drink during a typical week? ____________________

Indicate Painful or Distressed Areas. Explain as fully as possible.





Please explain if you have had any of the following within the last 3 months

GENERAL:

( ) Poor Appetite
( ) Changes in Appetite
( ) Weight Loss
( ) Weight Gain
( ) Peculiar Tastes or Smells
( ) Cravings (circle all that apply)
sugar salt sour spicy

( ) Strong Thirst
( ) Fevers
( ) Chills
( ) Sweating Easily
( ) Night Sweats
( ) Bleed or Bruise easily
( ) Tremors

( ) Fatigue
( ) Poor Sleep / Trouble Sleeping
( ) Poor Balance
( ) Localized Weakness
( ) Sudden Energy Drop
Time of Day ____________

SKIN & HAIR

( ) Rashes
( ) Itches
( ) Dandruff
( ) Change in hair or skin texture

( ) Ulcerations
( ) Eczema
( ) Hair loss

( ) Hives
( ) Pimples
( ) Recent Moles

Other ____

CARDIOVASCULAR

( ) High Blood Pressure
( ) Irregular heartbeat
( ) Cold Hands or Feet
( ) Blood Clots

( ) Low Blood Pressure
( ) Dizziness
( ) Swelling of Hands
( ) Phlebitis

( ) Chest Pain
( ) Fainting
( ) Swelling in Feet
( ) Difficulty in Breathing

Other Heart or Circulatory Problems ____

RESPIRATORY:

( ) Cough
( ) Bronchitis

( ) Coughing Up Blood
( ) Pneumonia

( ) Asthma
( ) Pain with Deep Breaths

( )Difficulty Breathing When Lying Down

( ) Production of Phlegm - Color? ___________________

Other Lung Problems ____

HEAD, EYES, EARS, NOSE & THROAT

( ) Recurrent Sore Throats
( ) Sores on Lips or Tongue
( ) Sinus Problems
( ) Nose Bleeds
( ) Facial Pain
( ) Concussion(s)
( ) Dizziness
( ) Migraines
( ) Ear Aches
( ) Poor Hearing
( ) Teeth Problems
( ) Grinding Teeth
( ) Clicking Jaw
( ) Night Blindness
( ) Glasses
( ) Color Blindness
( ) Poor Vision
( ) Cataracts
( ) Ringing in Ears
( ) Blurry Vision
( ) Eye Strain
( ) Eye Pain
( ) Spots in Front of Eyes

Headaches - where & when ____

Other head or neck problems ____

GASTROINTESTINAL

( ) Nausea
( ) Constipation
( ) Black Stools
( ) Bad Breath
( ) Abdominal Pain or Cramps
( ) Vomiting
( ) Gas
( ) Blood in Stools
( ) Rectal Pain
( ) Diarrhea
( ) Belching
( ) Indigestion
( ) Hemorrhoids

Other Stomach or Intestinal Problems _________________________

GENITO-URINARY

( ) Pain on Urination
( ) Urgent Urination
( ) Decrease in Urine Flow
( ) Frequent Urination
( ) Unable to Hold Urine
( ) Kidney Stones
( ) Blood in urine
( ) Sores on Genitals
( ) Impotence

( ) Waking at night to Void - How Often _____________________

Color of Urine ______________

Other Problems with Genitalia or Urinary System ____

REPRODUCTIVE & GYNECOLOGIC

Pregnancies __________
Births _______________
Miscarriages _________
Abortions ____________
Last PAP ____________

Date of Last menses ____________
Length of Menses _____________
Days Between Menses __________
Flow ( ) Heavy ( ) Light
Clots ( ) Dark ( ) Red

( ) Irregular Periods
( ) No Periods
( ) Breast Lumps or Pain
( ) Chronic Yeast Infections
( ) Menopause - Age _________

Birth Control Type & Length of Use ____

Pain with Cycle ( ) Beginning ( ) Ending ( ) Ovulation

PMS ( ) Psyche ( ) Body

Vaginal Discharge/Leukorrhea - please describe ____

MUSCULOSKELETAL

( ) Neck pain
( ) Back Pain
( ) Hand/Wrist Pain
( ) Muscle Pain
( ) Muscle Weakness
( ) Shoulder Pain
( ) Knee Pain
( ) Foot/Ankle Pain
( ) Hip Pain

Other Joint or Bone Problems ____

NEUROPSYCHOLOGICAL

( ) Seizures
( ) Areas of Numbness
( ) Concussion
( ) Bad Temper
( ) Dizziness
( ) Lack of Coordination
( ) Depression
( ) Low Tolerance for Stress
( ) Loss of Balance
( ) Poor memory
( ) Anxiety

Have you been treated for emotional problems? _______ Have you considered or attempted suicide?_______