HEALTH QUESTIONNAIRE

List all your current health problems:

_____

List all other health care providers seen for this/these condition(s):

_____

List and date all surgeries you have had:

_____

List all falls, injuries, broken bones, and/or hospitalizations you have ever had: Cause?

_____

Please check the conditions you have ever had:

☐ AIDS or HIV+	☐ Epilepsy or Seizures	☐ Polio
☐ Anemia	☐ Diabetes	☐ Rheumatic Fever
☐ Rheumatoid Arthritis	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Cancer	☐ Hepatitis	☐ Lupus
☐ Cerebral Palsy	☐ Muscular Dystrophy	☐ Stroke
☐ Heart Attack	☐ Aneurysm	☐ Other Disease:_____

List all current medications you are taking:

_____

_____

Do you have any medical allergies? ☐ Yes ☐ No

Please List :_____

Typical Reactions Include :_____

Start Date: _____ End Date: _____

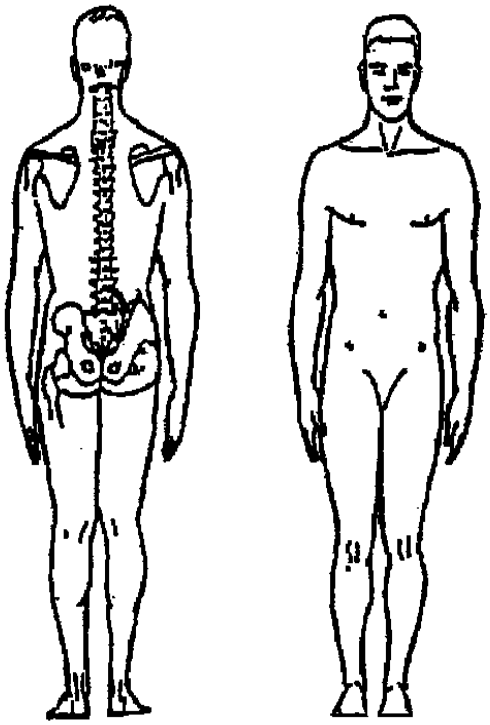
Do you have any other types of allergens? ☐ Yes ☐ No

Please List : _____

Typical Reactions Include :_____

Start Date: _____ End Date: _____

MUSCULOSKELETAL SYSTEM



COMPLETE THESE DIAGRAMS:

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. (For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.)

_____

_____

_____

_____

_____

List all areas of pain: _____

_____

List all areas of muscle spasms: _____

_____

List all areas of swelling: _____

_____

List all areas of weakness: _____

_____

List all areas of numbness or tingling: _____

_____

List all areas of stiffness or reduced motion: _____

_____

SYSTEMS REVIEW

Please check the conditions you have ever had:

EYES

- ☐ Eye Pressure/Pain
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Light Sensitivity
- ☐ Watery/Itchy Eyes
- ☐ Glasses/Contact Lenses
- ☐ Other _____

EARS

- ☐ Ear Pain
- ☐ Frequent Infections
- ☐ Tinnitus/ Ringing
- ☐ Vertigo
- ☐ Hearing Loss
- ☐ Other _____

MOUTH & THROAT

- ☐ Frequent Sore Spots
- ☐ Tooth Pain
- ☐ Mouth Sores/Ulcers
- ☐ Bleeding Gums
- ☐ Loss of Taste
- ☐ Difficulty Swallowing
- ☐ Voice Changes
- ☐ Other _____

NOSE & SINUSES

- ☐ Regular Nose Bleeds
- ☐ Sinus Pressure
- ☐ Frequent Runny Nose
- ☐ Sinusitis
- ☐ Loss of Smell
- ☐ Deviated Septum
- ☐ Other _____

RESPIRATORY

- ☐ Asthma
- ☐ Frequent Bronchitis
- ☐ Shortness of Breath
- ☐ Recurrent Cough
  - ☐ Dry ☐ Productive
- ☐ Can Not Sleep Lying Down
- ☐ Wheezing
- ☐ Other _____

SOCIAL HISTORY

- ☐ Smoker

  Start Date: _____

  Start Date: _____
- ☐ Alcohol Use

  Amount per week: _____
- ☐ Caffeinated Beverages

  Amount per day: _____

CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ Angina
- ☐ Previous Heart Attack
- ☐ Irregular Heart Beat
- ☐ Pounding Heart
- ☐ Heart "skips beats"
- ☐ General Swelling
- ☐ Ankle Swelling
- ☐ Fainting Spells
- ☐ Varicose Veins
- ☐ Phlebitis
- ☐ Blood Clot in Leg
- ☐ Poor Circulation
- ☐ Frequent Leg Cramps
- ☐ Slurred Speech
- ☐ Sudden Memory Loss
- ☐ Other _____

GENITOURINARY

- ☐ Painful Urination
- ☐ Difficulty Starting Stream
- ☐ Prostatitis
- ☐ Frequent Bladder Infections
- ☐ Lack of Bladder Control
- ☐ Cloudy/Bloody Urine
- ☐ Other _____

GASTROINTESTINAL

- ☐ Frequent Nausea
- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Frequent Indigestion
- ☐ Gastric Reflux
- ☐ Frequent Gas/Cramping
- ☐ Lactose Intolerance
- ☐ Change in Bowel Habits
- ☐ Frequent Diarrhea
- ☐ Frequent Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Other _____

SKIN, HAIR, & NAILS

- ☐ Dry Skin/Scalp
- ☐ Oily Skin/Scalp
- ☐ Eczema
- ☐ Psoriasis
- ☐ Yellow Skin
- ☐ Nail Ridges/Spots
- ☐ Recent Hair Loss
- ☐ Rapid Hair Loss
- ☐ Rapid Hair Graying
- ☐ Frequent Bruising
- ☐ Irregular Mole/Spots

DIET

- ☐ Balanced
- ☐ Not Balanced
- ☐ I eat 5+ Fruits/Veggies Per Day

SLEEP

- ☐ Sufficient
- ☐ Not Sufficient
- ☐ I get 7+ Hours/Night

EXERCISE

- ☐ Sufficient
- ☐ Not Sufficient
- ☐ At least 3x/Week

FAMILY STRESS

- ☐ Severe
- ☐ Moderate
- ☐ Mild

JOB STRESS

- ☐ Severe
- ☐ Moderate
- ☐ Mild