HEALTH QUESTIONNAIRE

Patient Name________________________________Age_____________DOB____________Sex_____Today's Date___________________

PRESENTING PROBLEM
Chief
Complaint____

____

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Date of Onset_________________________Presently working?_______________Date last worked_________________________________
Previous injuries:____
Right/Left Handed______________________ X-ray done recently____
Previously treated for this condition?____
Are you undergoing therapy? If so, by whom, where & how long?____
Occupation____

FAMILY HISTORY (if any blood relatives have suffered any of the following, please circle and indicate which one)

1. EPILEPSY	6. THYROID	11. OSTEOPOROSIS	16. HIGH CHOLESTEROL
2. MIGRAINE S	7. HAY FEVER	12. ARTHRITIS	17. ALCOHOLISM
3. MENTAL ILLNESS	8. ASTHMA	13. HEART DISEASE	18. CANCER
4. GLAUCOMA	9. ANEMIA	14. STROKE	19.
5. DIABETES	10. BLOOD DISORDER	15. HYPERTENSION	20.

SURGERY/HOSPITAL ADMISSION **YEAR** **OPERATION**
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LIST ALL MEDICATION YOU ARE TAKING____
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ALLERGIES____
LAST TETANUS/____

MEDICAL HISTORY (If not current, please put the date)

___Diabetes	**___Shortness of Breath**	**___Kidney Stones**
___Thyroid Disease	**___Irregular Pulse**	**___Venereal Disease**
___Muscle Weakness	**___Palpitations**	**___ Chronic Fatigue**
___Numbness/Tingling Sensation	**___Leg Pain when walking**	**___ Weight Loss**
___Arthritis/Rheumatism	**___Varicose Veins**	**___ Anemia**
___Neck/Back Pain	**___Loss of Appetite**	**___ Headaches**
___Bone Fracture/joint Injury	**___Difficulty Swallowing**	**___ Foot Pain**
___Gout	**___Heartburn**	**___ Rashes**
___Osteoporosis	**___Peptic Ulcer**	**___ Psoriasis**
___Decreased Hearing	**___Nausea/Vomiting**	**___ Difficulty Sleeping**
___Ringing in Ear	**___Abdominal Pain**	**___ Depression**
___Ear Infection	**___Gall Bladder Trouble**	**___ Memory Loss**
___Double or Blurred Vision	**___Jaundice/Hepatitis**	**___ Mental Illness**
___Eye Infection	**___Change in Bowel Habits**	**___ Chicken Pox**
___Nose Bleeds	**___Diarrhea**	**___ Polio**
___Sinus Trouble	**___Constipation**	**___ Measles**
___Hay Fever	**___Diverticulitis**	**___ Tuberculosis**
___Hoarseness	**___Crohn's/Colitis**	**___ Mumps**
___Pneumonia	**___Blood in the stool**	**___ Scarlet fever**
___Bronchitis/Chronic Cough	**___Hemorrhoids**	**___ Herpes**
___Asthma/Wheezing	**___Urine Infection**	**___Polio**

Pregnant : YES__________NO___________ Regular Exercise: YES____________NO___________
Smoking: YES__________NO___________CIG/DAY_____________
Alcohol: YES__________NO___________FREQENCY___________
NOTES:____
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Patient Signature____ **Date**______________________________________