

# 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?

List all medications you are currently taking:

Please check the conditions you have ever had:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AIDS or HIV+         | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Polio              |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Lupus              |
| <input type="checkbox"/> Cerebral Palsy       | <input type="checkbox"/> Muscular Dystrophy  | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Aneurysm            | <input type="checkbox"/> Other Disease_____ |

# SYSTEMS REVIEW

## MUSCULOSKELEETAL SYSTEM

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/Tingling:

List all areas of stiffness/reduced motion:

## **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 throats
- Tooth pain
- Mouth sores/ulcers
- Bleeding gums
- Loss of taste
- Difficulty swallowing
- Voice changes
- Other \_\_\_\_\_

## **NOSES & 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't sleep lying down
- Wheezing
- Chest tightness
- Other \_\_\_\_\_

**CARDIOVASCULAR**

- High blood pressure
- Angina
- Previous heart attack
- Irregular heartbeat
- Pounding heart
- Heart "skips beats"
- General swelling
- Ankle swelling
- Fainting spells
- Varicose veins
- Phlebitis
- Blood clot in leg
- Poor circulation
- Frequent leg cramps
- Regular fainting spells
- 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 graying
- Frequent bruising
- Irregular mole/spot
- Other \_\_\_\_\_

**DIET**

- Balanced
- Not balanced
- I eat 5 fruits +/- or vegts per day

**SLEEP**

- Sufficient
- Not sufficient
- I get 7+ hrs sleep per night

**EXERCISE**

- Sufficient
- Not sufficient
- I exercise 3+ times per wk

**FAMILY STRESS**

- Severe
- Moderate
- Mild

**JOB STRESS**

- Severe
- Moderate
- Mild

**SMOKING HISTORY**

- Smoking
- Amount per day \_\_\_\_\_

How long \_\_\_\_\_

- Other tobacco use

How long \_\_\_\_\_

- Alcohol use

Amount per week \_\_\_\_\_

- Caffeinated beverages

Amount per day \_\_\_\_\_