HEALTH QUESTIONNAIRE

Name:_____ Date:_____

* For the following conditions please check: ☐ for ***previously*** had, ○ for ***presently*** have.

General:

- ☐ ○ Alcoholism
- ☐ ○ Anemia
- ☐ ○ Cancer
- ☐ ○ High cholesterol
- ☐ ○ Diabetes
- ☐ ○ Epilepsy/Seizures
- ☐ ○ Thyroid
- ☐ ○ Gout
- ☐ ○ Hypoglycemia
- ☐ ○ Multiple sclerosis
- ☐ ○ Osteoarthritis
- ☐ ○ Parkinson's disease
- ☐ ○ Pneumonia
- ☐ ○ Polio
- ☐ ○ Rheumatic fever
- ☐ ○ Rheumatoid arthritis
- ☐ ○ Depression
- ☐ ○ Tuberculosis
- ☐ ○ Ulcers
- ☐ ○ Venereal Disease
- ☐ ○ Skin Problems

Resistance to infection:

- ☐ ○ Catch colds easily
- ☐ ○ Frequent sinus trouble
- ☐ ○ Frequent influenza

Gastrointestinal:

- ☐ ○ Gall bladder problem
- ☐ ○ Liver trouble/Hepatitis
- ☐ ○ Excessive thirst
- ☐ ○ Distress from greasy foods
- ☐ ○ Pain over Stomach
- ☐ ○ Burning in stomach relieved by eating
- ☐ ○ Burping or bloating (if bloating, where?)_____
- ☐ ○ Heartburn
- ☐ ○ Nausea
- ☐ ○ Diarrhea
- ☐ ○ Blood in stool
- ☐ ○ Metallic taste in mouth
- ☐ ○ Mucus in stool
- ☐ ○ Colitis
- ☐ ○ Hiatal hernia
- ☐ ○ Vomiting
- ☐ ○ Constipation
- ☐ ○ Recent weight gain
- ☐ ○ Recent weight loss

Cardiovascular:

- ☐ ○ Pain over heart
- ☐ ○ Heart attack
- ☐ ○ Swelling in ankles
- ☐ ○ Irregular heartbeat
- ☐ ○ Stroke
- ☐ ○ Shortness of breath on exertion
- ☐ ○ Low blood pressure
- ☐ ○ High blood pressure
- ☐ ○ Pressure over chest

Nervous System:

- ☐ ○ Dizziness/Lightheaded
- ☐ ○ Fainting
- ☐ ○ Discoordination

Eye, Ear, Nose and Throat:

- ☐ ○ Vision problems
- ☐ ○ Hearing loss
- ☐ ○ Ear pain
- ☐ ○ Dental problems
- ☐ ○ Nose bleeds
- ☐ ○ Difficulty breathing through nose
- ☐ ○ Hoarseness
- ☐ ○ Sore throat

☐ ○ Memory loss ☐ ○ Ear noises ☐ ○ Difficult speech

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Urinary Tract:

☐ ○ Blood in urine
☐ ○ Inability to control urination
☐ ○ Painful urination
☐ ○ Bladder infection
☐ ○ Kidney stones

Respiratory:

☐ ○ Chest pain
☐ ○ Coughing up blood
☐ ○ Difficulty breathing
☐ ○ Shortness of breath
☐ ○ Allergies
☐ ○ Chronic cough
☐ ○ Spitting up phlegm
☐ ○ Emphysema
☐ ○ Asthma

Women Only:

☐ ○ Irregular periods
☐ ○ Hot flashes
☐ ○ Vaginal discharge
☐ ○ Menopausal symptoms
☐ ○ Headaches with period
☐ ○ Menstrual cramps
☐ ○ Excessive flow
☐ ○ Hysterectomy
☐ ○ Premenstrual depression
☐ ○ Painful breasts
☐ ○ Lumps in breasts

Men Only:

☐ ○ Burning on urination
☐ ○ Prostate trouble
☐ ○ Feeling of incomplete bowel evacuation
☐ ○ Need to get up at night to urinate
☐ ○ Difficulty starting urine
☐ ○ Dripping after urination

Blood Sugar:

☐ ○ Irritable before meals
☐ ○ Get "shaky" if hungry
☐ ○ "Lightheaded" if meals delayed
☐ ○ Fatigue relieved by eating
☐ ○ Heart palpitates if meals are missed/delayed
☐ ○ Awaken after a few hours sleep, hard to get back to sleep
☐ ○ Moods of depression - "blues" or melancholy
☐ ○ Abnormal craving for sweets or snacks

Neuromusculoskeletal

☐ ○ Headaches
☐ ○ Upper extremity pain
☐ ○ Neck pain
☐ ○ Lower extremity pain
☐ ○ Low back pain
☐ ○ Tingling in hands or feet

Please list all conditions that you are currently being treated for:

Condition	Medications	Doctor	Date of Last Treatment

Medical History

Have you been treated for any conditions in the last year? ◯ No ◯ Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? ◯ No ◯ Yes

Have you had X-rays taken? ◯ No ◯ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	◯	◯	
Been hospitalized?	◯	◯	
Been in an auto accident?	◯	◯	
Had Sprains/Strains?	◯	◯	
Been struck unconscious?	◯	◯	
Had surgery?	◯	◯	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	◯ No	◯ Yes
Do your symptoms interfere with daily life?	◯ No	◯ Yes
Does pain wake you up at night?	◯ No	◯ Yes
Are your symptoms worse during certain times of the day?	◯ No	◯ Yes
Do changes in weather affect your symptoms?	◯ No	◯ Yes
Do you wear orthotics?	◯ No	◯ Yes
Do you take vitamin supplements?	◯ No	◯ Yes

What activities aggravate your symptoms?

Habits	None	Light	Moderate	Heavy
Alcohol	◯	◯	◯	◯
Coffee	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯
Drugs	◯	◯	◯	◯
Exercise	◯	◯	◯	◯
Sleep	◯	◯	◯	◯
Appetite	◯	◯	◯	◯
Soft Drinks	◯	◯	◯	◯
Water	◯	◯	◯	◯
Salty Foods	◯	◯	◯	◯
Sugary Foods	◯	◯	◯	◯
Artificial Sweeteners	◯	◯	◯	◯