

Health Questionnaire

Name: _____ Date: _____

1. Please list all medical complaints in order of importance:

2. Please list all prescription medications you are taking:

Name of Medication	Reason for Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. List Vitamins and Supplements you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____

4. Please list all surgeries and the year they were performed:

_____	_____
_____	_____
_____	_____
_____	_____

5. Family History

	Age	Health Issues and/or cause of death
Mother:	_____	_____
Father:	_____	_____
Mother's Mother:	_____	_____
Mother's Father:	_____	_____
Father's Mother:	_____	_____
Father's Father:	_____	_____
Brothers:	_____	_____
Sisters:	_____	_____
Children:	_____	_____

6. Please check the Conditions you have or have had:

- | | | |
|---|---|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Muscular Dystrophies |
| <input type="checkbox"/> Allergic Rhinitis (nose irritation, hay fever) | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> ALS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteomyelitis |
| <input type="checkbox"/> Alzheimers Disease | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Embolism | <input type="checkbox"/> Parkinsons Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Peritonitis |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Pneumonia, Whooping Cough |
| <input type="checkbox"/> Arterial Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Ashtma | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Psychotic or Schizophrenic Disorders |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pulmonary Heart Disease |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Benign Tumors | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Hernia | <input type="checkbox"/> Septicemia |
| <input type="checkbox"/> Bowel Obstruction/Blockage | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> HIV sero-positive | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Human Papillomavirus (HPV) | <input type="checkbox"/> Spondylolithiasis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Subdural hematoma |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Ileitis | <input type="checkbox"/> Thyroid Gland-hyper/hypo |
| <input type="checkbox"/> Cerebral Vascular Accident | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cervical Spine Bifida | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Lupus | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Coma | <input type="checkbox"/> Macular Eye Degeneration | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Multiple Myeloma | <input type="checkbox"/> Thrombophlebitis |

7. Miscellaneous

Social History

- Smoking
- Other Tobacco Use
- Alcohol Use
- Drug Use
- Drink Coffee/Tea
- Diet is: Balanced / Not Balanced
- Rest is: Sufficient / Not Sufficient
- Recreation is: Sufficient / Not Sufficient
- My Family Stress is: Severe / Moderate / Minimal / None
- How do you like work: I love it / It's OK / I hate it
- My Job Stress is: Severe / Moderate / Minimal / None

8. Please list all present symptoms for the Musculoskeletal System

Head

- Frequent headaches
- Severe headaches
- Head feels heavy
- Vertigo
- Light Headed
- Loss of smell
- Loss of taste
- Loss of balance
- Dizziness

Neck

- Pain in Neck
- neck pain with movement
- swelling in neck
- Stiff neck
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Limited neck movement

Arms /Hands

- Pain in upper arm
- Pain in forearm
- Pain in hands
- Pain in fingers
- Sensation of pins and needles
 - in arms
 - in fingers
- Fingers go to sleep
- Hands cold
- Swollen joints in fingers
- Sore joints in fingers
- Loss of grip strength

Mid Back

- Mid back pain
- Pain between shoulder blades
- Sharp stabbing pain
- Dull Ache
- Pain from front to back
- Pain over kidney area
- Muscle spasms in mid back

Low Back

- Low back Pain
- Low back feels out of place
- Muscle spasms in low back

Hips/Legs/Feet

- Pain in buttocks
- Pain down leg
- Knee Pain
- Leg cramps
- Pins & Needles in legs
- Numbness in leg
- Numbness in toes
- Cold feet
- Swollen ankles
- Swollen Feet

Shoulders

- Pain in shoulders R/L
- Pain across shoulders
- Tension in shoulders
- Muscle spasms shoulders
- Cant raise arms
 - above shoulder level
 - over head

9. Have you ever been in an accident: yes/no

When was the Accident: _____ Injuries: _____

Type of Accident: Auto/Work-On Job/ At Home/Other