HEALTH QUESTIONNAIRE

NAME	HEIGHT	WEIGHT	TODAY'S DATE

FAMILY HISTORY — *HAS ANY BLOOD RELATIVE EVER HAD ANY OF THE FOLLOWING:*

	YES	NO		YES	NO		YES	NO		YES	NO
CANCER			HIGH BLOOD PRESSURE			MENTAL ILLNESS			THYROID DISEASE		
TUBERCULOSIS			STROKE			BLEEDING TENDENCIES			GALLBLADDER DISEASE		
DIABETES			CONVULSIONS			ARTHRITIS			ULCERS		
HEART CONDITION			SUICIDE			KIDNEY CONDITION			STOMACH PROBLEMS		

CURRENT MEDICAL HISTORY

HAVE THERE BEEN ANY CHANGES IN YOUR MEDICAL CONDITION WITHIN THE LAST SIX MONTHS? (OR HAVE YOU BEEN TREATED FOR A MEDICAL CONDITION WITHIN THE LAST YEAR?) ☐ YES ☐ NO

IF YES, WHAT WERE THOSE CONDITIONS? ____________________

HAVE YOU BEEN HOSPITALIZED WITHIN THE LAST YEAR? ☐ YES ☐ NO

IF YES, FOR WHAT? ____________________

HAVE YOU HAD ANY SURGERY IN THE PAST YEAR? ☐ YES ☐ NO

IF YES, FOR WHAT? ____________________

ALCOHOL: ☐ SOCIAL DRINKER ☐ HEAVY DRINKER ☐ OCCASIONAL ☐ NEVER

TOBACCO (SMOKE OR CHEW): NUMBER OF PACKS PER DAY__________ IF QUIT, HOW LONG?__________

ALLERGIES AND SENSITIVITIES — *HAVE YOU EXPERIENCED ANY REACTION FOLLOWING THE ADMINISTRATION OF:*

	YES	NO	DON'T KNOW
PENICILLIN OR OTHER ANTIBIOTICS			
MORPHINE, CODEINE, DEMEROL, OR OTHER NARCOTICS			
ASPIRIN, EMPIRIN, OR OTHER PAIN REMEDIES			
SULFA DRUGS			
TETANUS ANTITOXIN OR OTHER SERUMS			
ADHESIVE TAPE OR SURGICAL TAPE			
ANY FOODS (i.e. EGGS, MILK, CHOCOLATE, ETC.)			

ARE YOU CURRENTLY TAKING ANY MEDICATION ☐ YES ☐ NO IF YES, WHAT TYPE(S) ____________________

ANY OTHER DRUGS OR MEDICATION ____________________

PERSONAL HISTORY — *PLEASE ANSWER* YES *OR* NO *TO ALL QUESTIONS BELOW:*

	YES	NO
1. FREQUENT OR SEVERE HEADACHES		
2. DIZZINESS OR FAINTING SPELLS		
3. RINGING IN THE EARS		
4. SINUS INFECTION		
5. EYE PROBLEM		
6. DO YOU WEAR GLASSES?		
7. EAR, NOSE OR THROAT PROBLEM		
8. HAY FEVER		
9. HOARSENESS		
10. DIFFICULTY SWALLOWING		
11. FREQUENT COLDS OR CHRONIC COUGH		
12. ASTHMA		
13. CHEST OR LUNG PROBLEM		
14. PNEUMONIA OR PLEURISY / LUNG PROBLEMS		
15. TUBERCULOSIS		
16. SWELLING OF EXTREMITIES		
17. PAIN OR PRESSURE IN CHEST / SHORTNESS OF BREATH		
18. PALPITATIONS OR POUNDING HEART		
19. ABNORMAL BLOOD PRESSURE ☐ HIGH ☐ LOW		
20. HEART PROBLEM OR MURMUR		
21. EXCESSIVE BLEEDING		
22. ANEMIA OR OTHER BLOOD CONDITION		
23. CLOTS IN LEGS OR VEIN PROBLEM		
24. FREQUENT NAUSEA, VOMITING OR INDIGESTION		
25. STOMACH, LIVER OR INTESTINAL PROBLEM		
26. HEPATITIS, JAUNDICE OR GALLBLADDER PROBLEM		
27. ULCER		
28. CHRONIC CONSTIPATION		
29. BLACK STOOLS		
30. URINARY, KIDNEY, BLADDER OR PROSTATE PROBLEM		

PLEASE EXPLAIN ANY* YES *ANSWERS ON THE REVERSE SIDE.

CONTINUED ON REVERSE SIDE

CONTINUED FROM REVERSE SIDE

PERSONAL HISTORY — *HAVE YOU EVER HAD ANY OF THE FOLLOWING:*

	YES	NO
31. EXCESSIVE FATIGUE		
32. UNEXPLAINED HIGH FEVER		
33. ENLARGED GLANDS		
34. TUMOR, GROWTH OR CANCER		
35. RECENT GAIN OR LOSS OF WEIGHT OVER 10 LBS.		
36. DIABETES		
37. EPILEPSY		
38. MEASLES, MUMPS OR CHICKEN POX		
39. SCARLET OR RHEUMATIC FEVER		
40. ARTHRITIS, GOUT OR RHEUMATISM		
41. FRACTURES, SPRAINS OR DISLOCATIONS		
42. PAINFUL OR SWOLLEN JOINTS		
43. BURSITIS, NEURITIS		
44. BONE INFECTIONS		
45. MUSCLE WEAKNESS / ATROPHY		

	YES	NO
46. NERVOUSNESS		
47. NEUROMUSCULAR / NEUROLOGICAL PROBLEMS		
48. DRINKING DEPENDENCY / DISORDER		
49. DRUG DEPENDENCY / DISORDER		
50. PSYCHOLOGICAL PROBLEMS		
51. CHRONIC DISORDERS		
52. SURGERIES / SERIOUS ILLNESSES		
53. NOTABLE ACCIDENTS / INJURIES		
54. ALLERGIES OR HIVES		
55. RASHES OR SKIN DISEASES		
56. PREGNANT, OR POSSIBLY PREGNANT AT PRESENT		
57. MENSTRUAL – DATE OF LAST PERIOD		
58. MENSTRUAL / PAP ABNORMALITIES		
59. OBSTETRICAL / GYN DISORDERS		
60. TAKEN ANTIBIOTICS		
61. TAKEN STEROIDS		

PLEASE EXPLAIN ANY* YES *ANSWERS. BE SURE TO NUMBER EACH EXPLANATION WITH ITEM NUMBER.