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# Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. Thank you.

Date of first visit: ___________

Name _____________________________________________ Date of Birth___________________

Address ________________________________________________________________
(Street) (City) (State) (Zip code)

Phone ________________________________________________________________ Sex __ Age ____
(Home) (Work) (Cell)

Height_____________________ Weight ________________ Marital Status: ______________________

Occupation: ___________________________ Employer:______________________________________

Family Physician _____________________________ Referred by ______________________________

Insurance Plan _______________________ Policy # __________________Subscriber_______________

In Emergency Notify ___________________________________________________________________

**Main Problem(s)**

Please list your current health problems you would like us to help you with ___________________________

___________________________________________________________________________________

___________________________________________________________________________________

How long ago did this problem begin (be specific)? ____________________________________________

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____________

___________________________________________________________________________________

Have you been given a diagnosis for this problem? If so, what? ___________________________________

What kind of treatment have you tried? _____________________________________________________

___________________________________________________________________________________

**Past Medical History** (please include dates)

**Significant Illnesses** (please circle all that apply): Cancer Diabetes Hepatitis High Blood Pressure

Heart Disease Rheumatic Fever Thyroid Disease Seisures Venereal Disease Other: ____________

**Surgeries:** ________________________________________________________________________

**Significant Trauma** (auto accidents, falls, etc.):_______________________________________________

**Birth History** (prolonged labor, forceps delivery, etc.):__________________________________________

**Allergies** (drugs, chemicals, foods, etc.): ____________________________________________________

**Family Medical History** (circle any that apply to family members):

Diabetes Cancer High Blood Pressure Seizures Asthma Allergies Heart Disease Stroke

**Occupation:**

Describe any occupational stress (chemical, physical, psychological, etc): ______________________________

______________________________________________________________________________

**Diet and Exercise:**

Are you or have you ever been on a restricted diet? Please describe: __________________________________

______________________________________________________________________________

Please describe your average daily diet:

| Morning | Afternoon | Evening |
|---|---|---|

How many packs of cigarettes do you smoke a day: ___________

How much coffee, tea, or cola do you drink per week: __________

How much alcohol do you drink per week: ___________

Please describe any use of drugs for non-medical purposes: ____________________________________________

Do you have a regular exercise program? Please describe: ______________________________________________

______________________________________________________________________________

Please check any you have had in the last three months:

**GENERAL**

θ Poor appetite
θ Poor sleeping
θ Fatigue
θ Fevers
θ Chills
θ Night sweats
θ Sweat easily
θ Tremors
θ Cravings
θ Localized weakness
θ Poor Balance
θ Change in appetite
θ Bleed or bruise easily
θ Weight loss
θ Weight gain
θ Peculiar tastes or smells
θ Strong thirst (cold or hot drinks)
θ Sudden energy drop (what time of day)

**SKIN AND HAIR**

θ Rashes
θ Ulcerations
θ Hives
θ Itching
θ Eczema
θ Pimples
θ Dandruff
θ Loss of hair
θ Recent moles
θ Change in hair or skin texture
θ Any other hair or skin problems?

**HEAD, EYES, EARS, NOSE, AND THROAT**

θ Dizziness
θ Concussion
θ Migraines
θ Glasses
θ Eye strain
θ Eye pain
θ Poor vision
θ Night blindness
θ Color blindness
θ Cataracts
θ Blurry vision
θ Earaches
θ Ringing in ears
θ Poor hearing
θ Spots in front of eyes
θ Sinus problems
θ Nose bleeds
θ Recurrent sore throats
θ Grinding teeth
θ Facial pain
θ Sores on lips or tongue
θ Teeth problems
θ Jaw clicks
θ Headaches (where and when?)
θ Any other head or neck problems?

**CARDIOVASCULAR**

θ High blood pressure θ Low blood pressure θ Chest pain
θ Irregular heartbeat θ Dizziness θ Fainting
θ Cold hands or feet θ Swelling of hands θ Swelling of feet
θ Blood clots θ Phlebitis θ Difficulty in breathing
θ Any other heart or blood vessel problems?

**RESPIRATORY**

θ Cough θ Coughing blood θ Asthma
θ Bronchitis θ Pneumonia θ Pain with a deep breath
θ Difficulty in breathing when lying down θ Production of phlegm (color?)
θ Any other lung problems?

**GASTROINTESTINAL**

θ Nausea θ Vomiting θ Diarrhea
θ Constipation θ Gas θ Belching
θ Black stools θ Blood in stools θ Indigestion
θ Bad breath θ Rectal pain θ Hemorrhoids
θ Abdominal pain or cramps θ Chronic laxative use
θ Any other problems with your stomach or intestines?

**GENITO-URINARY**

θ Pain on urination θ Frequent urination θ Blood in urine
θ Urgency to urinate θ Unable to hold urine θ Kidney stones
θ Decrease in flow θ Impotency θ Sores on genitals
θ Do you wake up to urinate (How often)?
θ Any particular color to your urine
θ Any other problems with your genital or urinary systems?

**PREGNANCY AND GYNECOLOGY**

____Number of pregnancies ____Number of births ____Premature births
____Miscarriages ____Abortions ____Age at first menses
____Period between menses ____Duration of flow ____First date of last menses
θ Unusual character (heavy or light) θ Painful periods
θ Clots θ Irregular periods θ Vaginal discharge
θ Vaginal sores θ Breast lumps ____Last PAP
θ Changes in body/psyche prior to menstruation
Do you practice birth control?_____________ What type and for how long?______________________

**MUSCULOSKELETAL**

θ Neck pain θ Muscle pain θ Knee pain
θ Back pain θ Muscle weakness θ Foot/ankle pain
θ Hand/wrist pain θ Shoulder pain θ Hip pain
θ Any other joint or bone problem?

**NEUROPSYCHOLOGICAL**

θ Seizures θ Dizziness θ Loss of balance
θ Areas of numbness θ Lack of coordination θ Poor memory
θ Concussion θ Depression θ Anxiety
θ Bad temper θ Easily susceptible to stress
θ Have you ever been treated for emotional problems?
θ Have your ever considered or attempted suicide?
θ Any other neurological or psychological problems?

**COMMENTS**

Is there any other problem you would like to discuss?

# PAIN ASSESSMENT

Chief Complaint(s): 1) _________________________ 2) _______________________________

Is your present problem due to an injury:
___ on the job? ___Auto accident? ___Personal injury? ___ Other: _______________

How did your pain begin?: _____ Gradually _____Suddenly

Do you have pain: _____All the time? _____ Sometimes?

Is your pain worse when you:
___ Sit ___ Bend ___ Walk ___ Lift ___Push ___Pull ___ Other: __________

Which of the following areas do you have the most pain, discomfort or restriction of motion in?
___ Neck ___ Shoulders ___ Arms ___ Hands ___ Upper back ___ Mid back
___ Lower back ___ Pelvis ___ Hips ___ Legs ___ Knees ___ Feet ___ Other: ______

Using the scale to the right, in an 8 hour day, rate the percentage of the time you spend:

Sitting: _____ % of the time
Standing: ______% of the time
Walking: _______% of the time

OCCASIONALLY = $33%
FREQUENTLY = 34 – 66%
CONTINUOUSLY = 67 – 100%

Again using the same scale, what percentage of your time are you:
Housebound: ________ %
Chairbound: ________ %
Bedfast: ___________ %

Rate the severeity of your pain by circling one of the numbers on the scale below.
1 = least pain, 10 = extreme pain

No pain 1 2 3 4 5 6 7 8 9 10 Extreme pain

Does your pain interfere with your: ____ Work? _____Sleep? _____Daily Routine?

Do you feel your present condition is: _____ Temporary? _____ Permanent? _____ Don't Know

List any additional comments you wish to make regarding your condition: ________________________________________

______________________________________________________________________________

______________________________________________________________________________

Patient Signature: ____________________________________________
Date: _____/_____/_____