HEALTH QUESTIONAIRE
Personal Information

Date _____

Name _____ Age _____ Sex M F

Place of Birth _____ Marital Status married single divorced widowed

Occupation _____ Ethnic Background _____

MEDICAL INFORMATION

Do you have any current or past medical conditions? (please circle all that apply)

Seizures	High blood pressure	*Neurological disorders	Migraines
Stroke	Diabetes	Glaucoma	Heart attack
Osteoporosis	Deafness	Heart failure	Arthritis
*Thyroid disease	*Irregular heart beat	*Bone deformities/fractures	*Kidney disease
Seasonal allergies	High cholesterol	Chronic back pain	Ulcers
Asthma/Emphysema	C O P D	*Intestinal disease	*Genital disease
Tuberculosis	*Liver disease	Incontinence	Valley fever
Hepatitis	*Cancer		

Other _____

_____

Please clarify any answers circled that have an * _____

_____

_____

_____

List any surgeries or hospitalizations for illness/injury _____

_____

_____

_____

_____

_____

_____

List any medication/food allergies _____

_____

_____

List all current medications:

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Habits (circle any that apply)

Amount /Frequency	Amount/Frequency	Amount/Frequency
Coffee _____	Tobacco_____	Tea _____
Drugs _____	Alcohol _____	Exercise _____

Family History (circle all that apply)

Thyroid disease	High Cholesterol	Obesity	Cancer: Specify
Asthma / Emphysema	Diabetes	Alzheimer's	Colon
Tuberculosis	Valley fever	Schizophrenia	Prostate
High blood pressure	Stroke	Osteoporosis	Breast
Heart disease	Kidney disease	Liver disease	Uterine
Other _____			Other cancer_____

_____

Are you currently experiencing any of the following (circle all that apply)

Weight gain/loss	Congestion	Urinary difficulty	Fevers
Chills	Difficulty breathing	Painful urination	Chest pain/pressure
Joint pain	Sweating	Headache	Palpitations
Muscle aches	Change in vision	Heartburn	New moles
Leg/arm swelling	Skin growth	Decreased hearing	Abdominal pain
Rash	Dizziness	Constipation	Itching
Weakness	Diarrhea	Lumps	Cough
Bloody or black stool	Bleeding		

Other _____

_____

Please list any physicians who care/cared for you _____

_____

_____

_____

_____

Females only:

Date of last menstrual cycle _____ Are you post-menopausal ? Y N

Are or were your cycles normal ? Y N

If no, give a brief explanation _____

_____

Do you or have you taken birth control pills? Y N

Do you or have you taken estrogen? Y N If yes, how long? _____

Do you or have you taken progesterone? Y N If yes, how long? _____

Did your mother or grandmother: Walk bent over? Fracture a hip? Get shorter with age?