

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionaire are strictly confidential and will become part of your medical record

Name:	0 м 0 ғ				DOB:				
Marital Status:	0 Single	0 Partnered	0 Married	0 Separated	0 Divorced	0 Widowed			
Referring Physician	n:		Addr	ess:					
PERSONAL HEALTH HISTORY									
Reason for Today's Visit									
Past Medical Proble	ems or Dise	eases/ Surgeri	es						
List your Prescribed	d Medicatio	ons							
Name of Drug		Strength			Frequency	Taken			

Allergies t	o Medications							
Name of Dr	rug	Reaction You Had						
Over-the-	Counter Medic	ations						
Name of Drug		Strength			Frequency Taken			
		SOCIAL A	ND OCCUPAT	FIONAL HIS	TORY			
Occupation								
Tobacco		Do you use tobaao? Yes No Current smokerpacks per day						
		Past smoker: Quityears ago						
Alcohol		Do you drink alcohol? Yes No						
		How many drinks per day per week per month						
Recreationa	al drugs	Do you use recreational drugs? Yes No						
Environmen	nvironmental exposures Prolonged exposure to toxic environment? Yes No							
	Past work with metals? Yes No							
		FAI	MILY HISTOR	RY				
Neurological Conditions								
Psychiatric Conditions								
Other								
		P	AIN REVIEW	1				
Are you cur	rently experienc	ing any pain? Y	es No If	yes, where a	nd for how long?			
	Circle a nur	mber from 1 to 10) that best rep	resents your o	current pain level.			
	0 1	2 2 4	-	, 7				
012345678910 No Pain A Lot of Pain Worst Imaginable Pain								
How would	you describe the	e pain?						
0 Aching	0 Burning	0 Cramping	0 Dull	O Heavy	O Deep			
0 Itching	0 Numb	0 Pounding	0 Pulling	0 Searing	0 Radiating			
0 Sharp	0 Shooting	0 Stabbing	0 Stinging	0 Throbbin	g 0 Tingling			
Is pain cons	stant or intermit	tent?						
l -	pain releaved b				There is no pain relief			

Review of Symptoms

(please check all that apply to you currently or in the recent past)

General symptoms

- o Fatigue
- o Recent unexplained weight loss or gain
- o Change in appetite
- o Unexplained fever
- o Disturbance of sleep pattern

Eyes/Ears/Nose/Mouth

- o Decreased, blurred or double vision
- o Excessively dry eyes
- o Episodes of eye inflammation
- o Ringing in ears
- o Dizziness/vertigo
- o Frequent sinus infections
- o Excessively dry mouth
- o Recurrent lip or mouth ulcers
- o Difficulty swallowing
- o Hoarseness/change in voice

Heart and Circulation

- o High blood pressure
- o Racing heart rate, irregula heart rhythm
- o History of heart attack or exertional chest pain
- o Blood clots in arms, legs or lungs

Stomach

- o Chronic constipation
- o Chronic diarrhea
- o Nausea and/or vomiting
- o Loss of bowel control

Lungs

- o Chronic cough
- Shortness of breath

Kidneys/Bladder

- o Difficulty urinating
- o Loss of bladder control
- o History of kidney stones

Muscles and Bones

- o Muscle pain or cramps
- o Joint pains

Skin

- o Unexplained rashes
- o Sun-sensitive or ill-feeling after sun exposure

Hormone-endocrine

- o Underactive or overactive thyroid gland
- o Other hormonal disorders
- o Miscarriages

Blood

- o History of anemia
- o Vitamin B12 deficiency
- o History of blood clots
- History of miscarriage

Psychological

- o Depression
- o Anxiety
- o Seen a psychiatrist or psychologist