HEALTH HISTORY QUESTIONNAIRE

Patient Name:____ **Date:**________________________________

Review of Systems

Please darken the circle next to any condition you have.

Constitutional

○ Fainting ○ low libido ○ Poor appetite ○ Fatigue ○ Sudden weight gain/loss (circle one) ○ Weakness ○ NONE

Respiratory

○ Asthma ○ Apnea ○ Emphysema ○ Hay fever ○ Shortness of breath ○ Pneumonia ○ NONE

Cardiovascular

○ High blood pressure ○ Low blood pressure ○ High cholesterol ○ Poor circulation ○ Angina ○ Excessive bleeding ○ NONE

Gastrointestinal

○ Anorexia/bulimia ○ Ulcer ○ Food sensitivities ○ Heartburn ○ Constipation ○ Diarrhea ○ NONE

Genitourinary

○ Kidney stones ○ Infertility ○ Bedwetting ○ Prostate issues ○ Erectile dysfunction ○ PMS symptoms ○ NONE

Integumentary

○ Skin cancer ○ Psoriasis ○ Eczema ○ Acne ○ Hair Loss ○ Rash ○ NONE

Neurological

○ Blurred vision ○ Ringing in ears ○ Hearing loss ○ Chronic ear infection ○ Loss of smell ○ Loss of taste ○ NONE

Endocrine

○ Thyroid issues ○ Immune disorders ○ Hypoglycemia ○ Frequent infection ○ Swollen glands ○ Low energy ○ NONE

Family History

Relative	Age (if living)	State of Health Good	State of Health Poor	Illnesses	Age at death	Cause of death Natural	Cause of death Illness
Mother	________	○	○	________________________	________	○	○
Father	________	○	○	________________________	________	○	○

Social History

	Daily	Weekly	None
Alcohol Use	○	○	○
Coffee Use	○	○	○
Tobacco Use	○	○	○
Exercise	○	○	○
Pain relievers	○	○	○
Soft Drinks	○	○	○
Water intake	○	○	○

Work History

Occupation:____

Job Requirements (lifting): ○ Sedentary (<10 lbs) ○ Light (<20 lbs)

○ Medium (<50 lbs) ○ Heavy (<100 lbs) ○ Very Heavy (+100lbs)

Have you missed work because of this accident? ○ No ○ Yes_________(days)

Who took you off work? ○ doctor ○ you did ○ boss ○ other____________

Do you continue to work despite the pain? ○ Yes ○ No

Did you lose your job as a result of this accident? ○ Yes ○ No

Are you working light or restricted duty? ○ Yes ○ No

Dominant Hand: ○ Right ○ Left ○ Ambidextrous (both)

Past Medical History

Illnesses

○ **None**

○ AIDS
○ Allergies
○ Cancer
○ Diabetes
○ Glaucoma
○ Gout
○ Hepatitis
○ Malaria
○ Multiple Sclerosis
○ Scarlet fever
○ Polio
○ Stroke
○ Typhoid fever
○ Other____________________________________
○ Other____________________________________

○ Alcoholism
○ Arteriosclerosis
○ Chicken Pox
○ Epilepsy
○ Goiter
○ Heart disease
○ HIV Positive
○ Measles
○ Mumps
○ Sexually transmitted disease
○ Rheumatic fever
○ Tuberculosis
○ Ulcer

Surgeries

○ **None**

○ Appendix removal
○ Cancer related
○ Eye surgery
○ Pacemaker
○ Vasectomy
○ Elective surgery:____________________________
○ Other surgery:______________________________

○ Bypass surgery
○ Cosmetic surgery
○ Hysterectomy
○ Tonsillectomy
○ Laparoscopy

Medications: Please list below all prescription, over-the-counter or natural supplements you are taking:____________________

____

____

____

Allergies: Are you allergic to any medications? ○ No ○ Yes

If yes, please list:__________________________________

____

Doctor's Initials