

Medical History Questionnaire

Date _____

Name _____

Address _____

City _____ Postal Code _____

Phone (H) _____ (C) _____ (B) _____

Date of Birth _____

Occupation _____

Marital Status _____ Number of Children _____

Emergency Contact _____ Relation _____

Phone _____

Leisure Activities _____

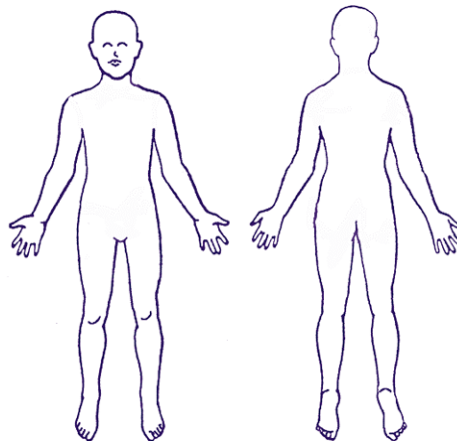
This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize us to do so.

What are you main health concerns in order of importance?

List any surgeries/scars/broken bones and major injuries and when they happened?

Pain rating scale

Using the following diagram to indicate areas of pain by placing an (X), areas of stiffness with (=), and areas of numbness with (//).



What, if any, is the previous diagnosis of your problem?

If you have had major illnesses in the past, or present, please list them and approximately when you had the illness?

Did you, or are you, suffering from any of the following?

- | | | |
|---------------------------------------------|--------------------------------------------------|-----------------------------------------------------------|
| <input type="radio"/> Change in appetite | <input type="radio"/> Dizziness/fainting | <input type="radio"/> Pain on urination |
| <input type="radio"/> Weight gain/loss | <input type="radio"/> Chest pain | <input type="radio"/> Wake up at night to urinate |
| <input type="radio"/> Cancer | <input type="radio"/> Varicose veins | <input type="radio"/> Incontinence |
| <input type="radio"/> Diabetes | <input type="radio"/> Cold hands or feet | <input type="radio"/> Kidney stones/infection |
| <input type="radio"/> Sleep disorder | <input type="radio"/> Swelling of limbs | <input type="radio"/> Blood in urine |
| <input type="radio"/> Fatigue | <input type="radio"/> Difficulty breathing | <u>Males</u> |
| <input type="radio"/> Chills/fever | <input type="radio"/> Chronic cough | <input type="radio"/> Prostate problems |
| <input type="radio"/> Strong thirst | <input type="radio"/> Asthma | <input type="radio"/> Impotence |
| <input type="radio"/> Skin problems | <input type="radio"/> Shortness of breath | <input type="radio"/> Infertility/low sperm |
| <input type="radio"/> Ear aches/infections | <input type="radio"/> Muscle weakness | <input type="radio"/> STD |
| <input type="radio"/> Ringing in ears | <input type="radio"/> Bursitis/Tendonitis | <input type="radio"/> Hernia |
| <input type="radio"/> Rash/Itching | <input type="radio"/> Indigestion | <u>Female</u> |
| <input type="radio"/> Eczema | <input type="radio"/> Gas or burping | <input type="radio"/> Irregular Periods heavy/light/clots |
| <input type="radio"/> Dry skin | <input type="radio"/> Bad breath | <input type="radio"/> Painful periods |
| <input type="radio"/> Hair growth/loss | <input type="radio"/> Constipation | <input type="radio"/> Vaginal discharge |
| <input type="radio"/> Enlarged glands | <input type="radio"/> Diarrhea | <input type="radio"/> Pregnant |
| <input type="radio"/> Recurrent sore throat | <input type="radio"/> Incomplete bowel movements | <input type="radio"/> Infertility |
| <input type="radio"/> Tonsillitis | <input type="radio"/> Nausea/Vomiting | <input type="radio"/> Sore breasts |
| <input type="radio"/> Nasal obstruction | <input type="radio"/> Chronic laxative use | <input type="radio"/> STD |
| <input type="radio"/> Post nasal drip | <input type="radio"/> Hemorrhoids | Age of first menses? ____ |
| <input type="radio"/> Nose bleeds | <input type="radio"/> Blood in stool | Menopausal? _____ |
| <input type="radio"/> Headaches | <input type="radio"/> Constant hunger | Pregnant? _____ |
| <input type="radio"/> Loss of taste/smell | <input type="radio"/> Poor memory | What type of birth control do you practice?
_____ |
| <input type="radio"/> Eye pain/strain | <input type="radio"/> Irritable/Anxiety | Number of: |
| <input type="radio"/> Vertigo | <input type="radio"/> Depression | • Pregnancies ____ |
| <input type="radio"/> Facial pain | <input type="radio"/> Lack of coordination | • Abortions ____ |
| <input type="radio"/> Jaw pain/click | <input type="radio"/> Concussion | • Miscarriages ____ |
| <input type="radio"/> Mercury fillings | <input type="radio"/> Loss of sensation | • Births ____ |
| <input type="radio"/> High blood pressure | <input type="radio"/> Hepatitis | |
| <input type="radio"/> Low blood pressure | <input type="radio"/> Tuberculosis | |
| <input type="radio"/> Heart attacks | <input type="radio"/> HIV/AIDS | |
| <input type="radio"/> Stroke | <input type="radio"/> Frequent urination | |
| <input type="radio"/> Pacemaker | <input type="radio"/> Urgency to urinate | |
| <input type="radio"/> Irregular heart beat | | |