

Health Questionnaire

Name _____ Date _____

1. Yes No Do you have high blood pressure?
2. Yes No Do you have heart problems?
3. Yes No Do you experience heart palpitations?
4. Yes No Do you have angina(chest pain)?
5. Yes No Do you have a heart murmur?
6. Yes No Do you experience angina with exertion?
7. Yes No Do you have shortness of breath?
8. Yes No Do you have asthma or allergies?
9. Yes No Do you have lung problems?
10. Yes No Do you smoke?
11. Yes No Have you experienced recent weight loss/gain?
12. Yes No Have you experienced recent loss of appetite?
13. Yes No Do you have any bladder or bowel problems(constipation, diarrhea, urgency, retention)?
14. Yes No Do you have thyroid problems?
15. Yes No Do you have diabetes?
16. Yes No Do you have or have you ever had cancer?
17. Yes No Do you have osteoporosis?
18. Yes No Do you have headaches?
19. Yes No Do you have frequent joint sprains, muscle strain?
20. Yes No Do you have unusual joint pain and swelling?
21. Yes No Do you have or have had any orthopedic injuries?
22. Yes No Do you have a history of back/neck pain?
23. Yes No Do you have a history of trauma?

Symptoms

What is your main complaint: _____

Please rate your pain: (please circle) (none) 1 2 3 4 5 6 7 8 9 10 (extreme)

1. Yes No Do your arms or legs fatigue easily?
2. Yes No Do you have any numbness or tingling?
3. Yes No Do you have any weakness in your arms or legs?
4. Yes No Do you have any coordination problems?
5. Yes No Do you have difficulty walking?
6. Yes No Do you experience dizziness with a change in position(e.g. from lying down to standing)?
7. Yes No Do you experience vertigo(feeling of spinning)?
8. Yes No Do you frequently lose your balance?
9. Yes No Have you fallen down?
10. Yes No Do you have episodes of blurred or double vision?
11. Yes No Do you wear contact lenses or glasses?
12. Yes No Do you have ringing in your ears?
13. Yes No Do you have fullness in the ears?
14. Yes No Do you have difficulty swallowing?
15. Yes No Do you experience hoarseness?

Please use this space to explain anything else in your history that you feel may be beneficial _____

Medications

Please list all medications and purpose _____

Please list all surgeries and approximate dates _____