



HEALTH HISTORY QUESTIONNAIRE

All of the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

Social/Health Habits:

- Do you smoke tobacco?** No Occasionally Socially Daily Heavily
Do you drink alcohol? No Occasionally Socially Daily Heavily
Do you recreational drugs? No Occasionally Socially Daily Heavily
Do you exercise? No Yes
 If yes, how many days per week? _____ minutes/day? _____
 Describe exercise or activity: _____

Employment/Work:

- Work Status:** Unemployed Working Full-time Working light duty Student
 Homemaker Working Part-time Disabled Retired
Occupation: _____

General Health Status:

- Please rate your health:** Excellent Good Fair Poor Don't Know
Major life Changes (past year): None Death in Family New Job Divorce Move

Family History:

Please check if anyone in your family has or had any of the following:

- | | | | |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Psychological problems |
| <input type="checkbox"/> Pulmonary/Lung disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Balance problems | <input type="checkbox"/> Other: | | |

Your Past Medical History:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> No history | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lung disorder | <input type="checkbox"/> Sleep disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lyme's Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Meniere's Disease | <input type="checkbox"/> Ulcers (stomach) |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Repeated infections |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Reoccurring Vertigo |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Genetic Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> _____ |

For women only:

- Pelvic Inflammatory Disease? No Yes Trouble with period? No Yes
 Complicated pregnancies? No Yes Currently pregnant? No Yes
 Endometriosis? No Yes Other: _____
 Increase in current symptoms with hormonal changes? No Yes

Surgical History:

Please list any surgeries you have had and, if known, include dates:

No surgeries to date

1. _____ Date: _____ 2. _____ Date: _____
3. _____ Date: _____ 4. _____ Date: _____

Symptom Checklist:

Within the last year, have you had any of the following (check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> No symptoms | <input type="checkbox"/> Headaches | <input type="checkbox"/> Syncope (passing out) |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Tinnitus (noises in your ear) |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Cough (persistent) | <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Difficulty driving | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Weakness in arms/legs |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Weight gain (unexplained) |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness in arms/legs | <input type="checkbox"/> Weight loss (unexplained) |
| <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Pain at night | <input type="checkbox"/> Dizziness with loud noises |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pressure in your ears | <input type="checkbox"/> Dizziness with physical exertion |
| <input type="checkbox"/> Foggy headedness | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Other: _____ |

Diagnostic Tests / Measures:

Within the last year, have you had any of the following (check all that apply):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> No diagnostic testing | <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Hearing tests | <input type="checkbox"/> Pulmonary Function Test |
| <input type="checkbox"/> Angiogram | <input type="checkbox"/> CT scan | <input type="checkbox"/> Mammogram | <input type="checkbox"/> Speech/Language evaluation |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> MRI | <input type="checkbox"/> Stool test |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Pap smear | <input type="checkbox"/> Stress test |
| <input type="checkbox"/> Blood test | <input type="checkbox"/> EEG | <input type="checkbox"/> EMG/Nerve conduction | <input type="checkbox"/> Urine test |
| <input type="checkbox"/> Bone scan | <input type="checkbox"/> EKG | <input type="checkbox"/> ENG | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> Other: _____ | | | |

Medications:

Please check or list all medications or allergies:

Non-Prescription:

- | | | |
|---|---|--|
| <input type="checkbox"/> No medications | <input type="checkbox"/> Decongestants | <input type="checkbox"/> Motrin |
| <input type="checkbox"/> Advil/Alleve | <input type="checkbox"/> Excedrin | <input type="checkbox"/> Vitamins/minerals |
| <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Herbal supplements | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen/Naproxen | <input type="checkbox"/> Other: _____ |

Prescription:

- No medications
 _____ _____ _____
 See attached list

Allergies:

- Drug allergies: No Yes, please list: _____
 Airborne pathogens: No Yes, please list: _____

Are you receiving any treatment for above stated allergies? If yes, please describe:
