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Confidential Health Questionnaire

Last Name: _____ First Name: _____ M.I. _____ Today's Date: _____

Preferred Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____

Occupation: _____ Employer/School: _____ Email: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ ext. _____ Cell: _____

How did you hear about me? _____

Present Health Concerns:

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?
1.	
2.	
3.	
4.	
5.	

What goals do you have for your visit today? _____

Health History

Last Name: _____ First Name: _____ Today's Date:_____

SYMPTOMS Check (√) symptoms you currently have or have had in the past year:

General

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

Genito-Urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Eye, Ear, Nose, Throat

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision- Flashes
- ☐ Vision – Halos

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN Only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

Women Only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

CONDITIONS Check (√) conditions you have or have had in the past:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Transfusion(s)
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List all medications you are taking currently:

Medications	Dose (mg.)	# Taken	How Often

Last Name: _____ First Name: _____ Today's Date:_____

SUPPLEMENTS List all supplements you are taking currently:			
Supplement	Dose	# Taken	How Often

Describe your diet: _____

_____

_____

_____

_____

_____

_____

ALLERGIES: List drugs that cause you an allergic reaction or sensitivity: _____

Hospitalizations and Surgeries:		
Hospital	Date	Reason

List any accidents that resulted in physical trauma:		
Injury	Date	Outcome

Describe any dental trauma, recent dental work (reason for work), history of TMJ, and teeth grinding history:		
Incidents	Date	Reason/History

Last Name: _____ First Name:_____ Today's Date:_____

Health Practices

Please answer the following questions. Please explain all YES answers in the space provided.

Regular aerobic exercise:	YES	NO	_____times/week	_____duration	
Smoking	YES	NO	_____packs/day	_____years	_____date quit
Alcohol use	YES	NO	_____drinks/week	_____years	
Caffeine	YES	NO	_____daily intake		

Past Medical History

Please list all personal medical history (i.e., hypertension, diabetes, etc.).

_____
_____
_____
_____
_____

Family History

Please list any major illnesses (cancer, stroke, and others):				
	Age	State of Health	Specific Ailment(s)	If deceased, age at death & cause
Father				
Mother				
Sister				
Sister				
Brother				
Brother				

Place a check if any blood relatives have had any of the following:		
√	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Colon Cancer	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Hypertension	
	Kidney Disease	
	Tuberculosis	
	Other:	