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CONFIDENTIAL HEALTH QUESTIONNAIRE
(PLEASE FAX/EMAIL/OR MAIL TO OUR OFFICE PRIOR TO YOUR APPT)

Today's Date _____ Soc. Sec. No._____

Name _____ Date of Birth _____

Spouse's Name OR Parent's Names (if patient is a minor) _____

_____yrs Married _____Divorced _____Single _____Separated

Address _____

_____

Home Phone _____Work Phone _____

Cell Phone _____ Fax _____ Email _____

Pharmacy Name _____ Phone #_____ Fax #_____

Emergency Contact _____ Phone _____

Occupation _____Race_____Ethnicity_____

How did you hear about our office?_____

MEDICAL HISTORY

Main reason for appointment:

Known Allergies to Medication:

Patient Name:_____
Date of Birth:_____

List Current Medications (including dosages, # of caps or tabs taken daily):

List Injuries (including date when injury occurred):

List Current Supplements (including dosages, # of caps or tabs taken daily)

Current Medical History of Patient (Check all that apply)

Signs/Symptoms:

_____Abnormal Heart Sounds ____Blood Pressure Reading Elevated _____Cough _____Diarrhea

_____Cachexia (weight loss, muscle atrophy, fatigue, weakness, loss of appetite) _____Heartburn

_____Hepatomegaly (enlarged liver) _____Incontinence urine/feces _____Lack of Coordination ____Murmur

_____Nausea _____Nausea with Vomiting _____Shortness of Breath ____Speech Disturbance

_____Tension Headache _____Viremia (Presence of viruses in the blood) ____Weight Loss ____Other: _____

Patient Name: _____
Date of Birth: _____

Current & Past Medical History of Patient (check all that apply)

Cardiovascular:

____Abnormal Aortic Aneurysm _____Abnormal Electrocardiogram ___Angina stable or unstable ____Aortic Stenosis

_____Atherosclerosis _____Atrial Fibrillation _____Atrial Flutter _____Atrioventricular Block

_____Congestive Heart Failure _____Coronary Heart Failure _____Heart Disease _____Heart Failure

_____Hypertension _____Hypertensive Heart Disease _____Other:_____

Respiratory:

_____Asthma _____Bronchitis (Acute or Chronic) _____Pneumonia (Bacterial or Viral) _____Rhinitis (Allergic or Chronic) _____Sinusitis, Chronic _____Other:_____

Digestive:

_____Appendicitis _____Blood in Stool _____Celiac Disease _____Colitis, ulcerative _____Colon

_____Constipation _____Diverticula of Intestine _____Esophageal Reflux _____Hemorrhoids _____Hepatitis

_____Hepatitis Chronic or Alcohol _____Hernia _____Irritable Bowel Syndrome _____Liver Disorder

_____RectalBleeding _____Stomach,Functional Disorder _____Vomiting ____Other:_____

Endocrine:

_____Anorexia _____Autoimmune Disease _____Chronic Fatigue Syndrome _____Cystic Fibrosis

_____Diabetes II (orals) ____Diabetes I (injectible) _____Endocrine Disorder _____Goiter

_____Hypercholesterolemia _____Hyperlipidemia _____Hyperthyroidism _____Hypothyroidism (Acquired or Congenital) _____Immunologic Disorder _____Metabolic Disorder _____Morbid Obesity _____Nutritional Defiency _____Obesity _____Ovarian Dysfunction _____Pituitary Gland Disorder _____Rickets, Acute

____Thyroiditis ____Weight Gain Abnormal ___Other: _____

Patient Name:_____
Date of Birth:_____

Neurologic:

_____Alzheimer's Disease _____Common Migraines _____Convulsions _____Encephalitis ____Gait Abnormality

_____Headache ____Meningitis _____Meningitis (Bacterial or Viral) _____Mild Cognitive Impairment

_____Motor Neuron Disease ____Multiple Sclerosis ____Muscle Weakness ____Neurologic Disorders

_____Neuropathy _____Parkinsonism, Secondary _____Post Stroke Paralysis _____Post Infectious Encephalitis

_____Progressive Musclar Atrophy ____Sleep Disorder ____Spinal Cord Disorder ____Spinal Muscle Atrophy

_____Transient Ischematic Attack (TIA) ____Other:_____

Renal/GU:

_____Chronic Interstitial Cystitis _____Chronic Kidney Disease _____Chronic Renal Failure _____Cystitis

_____Diabetes Nephropathy _____HIV, infection _____Urinary Incontinence

_____Other:_____

Hematologic:

_____Anemia _____Specific Type of Anemia_____

_____Coagulation Defect _____Hematological Disorder _____White Blood Cell Disorder

_____Other:_____

Musculoskeletal:

____Arthritis ____Backache ____Bone Infection ____Bunion ____Joint Disorder ____Joint Pain

____Muscular Spasm ____Musculoskeletal Deformity, Aquired ____Osteopenia ____Osteoporosis

_____Periostitis ____Sciatica ____Sprain and Strain ____TMJ ____Other:_____

Breast:

____Abnormal Mammogram ____Other:_____

Patient Name:_____
Date of Birth:_____

Skin:

____Acne ____Eczema ____Edema ____Malignant Melanoma of Skin ____Scleroderma ___Other:_____

Psychiatry:

____Acute reaction to stress ____Alcohol Withdrawal____Bipolar____Major Depression (recurrent)____Major Depression (single episode)____Manic Affective Disorder____Mental Retardation____Neurotic Depression

____Panic Disorder____Schizophrenia ____Other:_____

Patient Surgical History: Please include type of surgery and year it was performed.

Patient's Family History

If family members have any of the following please identify which by the following: (Mother = **M**, Father = **F**; Brother = **B**; Sister = **S**; Grandmother (Maternal) = **GMM**; Grandmother (Paternal) **GMP**; Grandfather (Maternal) **GFM**; Grandfather (Paternal) **GFP**; Child = **C**; Aunt = **A**; Uncle = **U**)

1.____ Back Problems 6. _____ Ulcers 11. _____ High Blood Pressure
2.____ Gall bladder Trouble 7. _____ Rheumatic fever 12. _____ Lyme Disease
3.____ Seizures 8. _____ Elevated Cholesterol 13. _____ Cancer: Type_____
4.____ Diabetes 9. _____ Thyroid Disease 14. _____ Liver Disease
5.____ Heart Disease 10. _____ Heart Attack 15. _____Stroke 16.___Kidney Problems

Please indicate past or present amounts:

	Daily	Weekly	Occasionally	Never	Past
Coffee/Caffeine					
Tobacco (packs/day)					
Alcohol (drinks per day/per week)					
Recreational Drugs					