

# HEALTH QUESTIONNAIRE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**For the following conditions please check:  for PREVIOUSLY had,  for PRESENTLY have**

## **General:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> <input type="radio"/> Alcoholism        | <input type="checkbox"/> <input type="radio"/> Gout                | <input type="checkbox"/> <input type="radio"/> Rheumatic Fever      |
| <input type="checkbox"/> <input type="radio"/> Anemia            | <input type="checkbox"/> <input type="radio"/> Hypoglycemia        | <input type="checkbox"/> <input type="radio"/> Rheumatoid Arthritis |
| <input type="checkbox"/> <input type="radio"/> Cancer            | <input type="checkbox"/> <input type="radio"/> Multiple Sclerosis  | <input type="checkbox"/> <input type="radio"/> Depression           |
| <input type="checkbox"/> <input type="radio"/> High cholesterol  | <input type="checkbox"/> <input type="radio"/> Osteoarthritis      | <input type="checkbox"/> <input type="radio"/> Tuberculosis         |
| <input type="checkbox"/> <input type="radio"/> Diabetes          | <input type="checkbox"/> <input type="radio"/> Parkinson's Disease | <input type="checkbox"/> <input type="radio"/> Ulcers               |
| <input type="checkbox"/> <input type="radio"/> Epilepsy/Seizures | <input type="checkbox"/> <input type="radio"/> Pneumonia           | <input type="checkbox"/> <input type="radio"/> Venereal Disease     |
| <input type="checkbox"/> <input type="radio"/> Thyroid           | <input type="checkbox"/> <input type="radio"/> Polio               | <input type="checkbox"/> <input type="radio"/> Skin problems        |

## **Resistance to Infection:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> <input type="radio"/> Catch colds easily | <input type="checkbox"/> <input type="radio"/> Frequent sinus trouble | <input type="checkbox"/> <input type="radio"/> Frequent Influenza |
|---|---|---|

## **Gastrointestinal System:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> <input type="radio"/> Gall bladder problem                  | <input type="checkbox"/> <input type="radio"/> Heartburn               | <input type="checkbox"/> <input type="radio"/> Mucus in stool     |
| <input type="checkbox"/> <input type="radio"/> Liver trouble/Hepatitis               | <input type="checkbox"/> <input type="radio"/> Nausea                  | <input type="checkbox"/> <input type="radio"/> Colitis            |
| <input type="checkbox"/> <input type="radio"/> Excessive thirst                      | <input type="checkbox"/> <input type="radio"/> Diarrhea                | <input type="checkbox"/> <input type="radio"/> Hiatal Hernia      |
| <input type="checkbox"/> <input type="radio"/> Distress from greasy foods            | <input type="checkbox"/> <input type="radio"/> Blood in stool          | <input type="checkbox"/> <input type="radio"/> Vomiting           |
| <input type="checkbox"/> <input type="radio"/> Pain over stomach                     | <input type="checkbox"/> <input type="radio"/> Metallic taste in mouth | <input type="checkbox"/> <input type="radio"/> Constipation       |
| <input type="checkbox"/> <input type="radio"/> Burping                               | <input type="checkbox"/> <input type="radio"/> Recent weight gain      | <input type="checkbox"/> <input type="radio"/> Recent weight loss |
| <input type="checkbox"/> <input type="radio"/> Burning in stomach relieved by eating |  |   |
| <input type="checkbox"/> <input type="radio"/> Bloating (where? _____)               |  |   |

## **Cardiovascular System:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> <input type="radio"/> Pain over heart    | <input type="checkbox"/> <input type="radio"/> Irregular heart beat | <input type="checkbox"/> <input type="radio"/> Low blood pressure              |
| <input type="checkbox"/> <input type="radio"/> Heart attack       | <input type="checkbox"/> <input type="radio"/> Stroke               | <input type="checkbox"/> <input type="radio"/> High blood pressure             |
| <input type="checkbox"/> <input type="radio"/> Swelling in ankles | <input type="checkbox"/> <input type="radio"/> Pressure over chest  | <input type="checkbox"/> <input type="radio"/> Shortness of breath on exertion |

## **Nervous System:**

- Dizziness/Lightheaded
- Fainting
- Discoordination
- Memory loss

## **Eye, Ear, Nose and Throat:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> <input type="radio"/> Vision Problems | <input type="checkbox"/> <input type="radio"/> Dental Problems                   | <input type="checkbox"/> <input type="radio"/> Hoarseness  |
| <input type="checkbox"/> <input type="radio"/> Hearing Loss    | <input type="checkbox"/> <input type="radio"/> Nose bleeds                       | <input type="checkbox"/> <input type="radio"/> Sore throat |
| <input type="checkbox"/> <input type="radio"/> Ear Pain        | <input type="checkbox"/> <input type="radio"/> Difficulty breathing through nose |  |
| <input type="checkbox"/> <input type="radio"/> Ear Noises      | <input type="checkbox"/> <input type="radio"/> Difficult speech                  |  |

## **Urinary Tract:**

- Blood in urine
- Inability to control urine
- Painful urination
- Bladder infection
- Kidney stones

## **Respiratory Tract:**

- |   |   |
|---|---|
| <input type="checkbox"/> <input type="radio"/> Chest Pain           | <input type="checkbox"/> <input type="radio"/> Chronic cough      |
| <input type="checkbox"/> <input type="radio"/> Coughing up blood    | <input type="checkbox"/> <input type="radio"/> Spitting up phlegm |
| <input type="checkbox"/> <input type="radio"/> Difficulty breathing | <input type="checkbox"/> <input type="radio"/> Emphysema          |
| <input type="checkbox"/> <input type="radio"/> Shortness of breath  | <input type="checkbox"/> <input type="radio"/> Asthma             |
| <input type="checkbox"/> <input type="radio"/> Allergies            |   |

PLEASE CONTINUE ON BACK



**For the following conditions please check:  for PREVIOUSLY had,  for PRESENTLY have**

**Women only:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> <input type="radio"/> Irregular periods   | <input type="checkbox"/> <input type="radio"/> Headaches with period | <input type="checkbox"/> <input type="radio"/> Premenstrual depression |
| <input type="checkbox"/> <input type="radio"/> Hot flashes         | <input type="checkbox"/> <input type="radio"/> Menstrual cramps      | <input type="checkbox"/> <input type="radio"/> Painful breasts         |
| <input type="checkbox"/> <input type="radio"/> Vaginal discharge   | <input type="checkbox"/> <input type="radio"/> Excessive flow        | <input type="checkbox"/> <input type="radio"/> Lumps in breasts        |
| <input type="checkbox"/> <input type="radio"/> Menopausal symptoms | <input type="checkbox"/> <input type="radio"/> Hysterectomy          |  |

**Men Only:**

- |   |   |
|---|---|
| <input type="checkbox"/> <input type="radio"/> Burning on urination                   | <input type="checkbox"/> <input type="radio"/> Need to get up at night to urinate |
| <input type="checkbox"/> <input type="radio"/> Prostate trouble                       | <input type="checkbox"/> <input type="radio"/> Difficulty starting urine flow     |
| <input type="checkbox"/> <input type="radio"/> Feeling of incomplete bowel evacuation | <input type="checkbox"/> <input type="radio"/> Dripping after urination           |

**Blood Sugar:**

- |  |  |
|--|--|
| <input type="checkbox"/> <input type="radio"/> Irritable before meals        | <input type="checkbox"/> <input type="radio"/> Heart palpitates if meals are missed/delayed              |
| <input type="checkbox"/> <input type="radio"/> Get “shaky” if hungry         | <input type="checkbox"/> <input type="radio"/> Awaken after a few hours sleep, hard to get back to sleep |
| <input type="checkbox"/> <input type="radio"/> “Lightheaded if meals delayed | <input type="checkbox"/> <input type="radio"/> Moods of depression — “blues” or melancholy               |
| <input type="checkbox"/> <input type="radio"/> Fatigue relieved by eating    | <input type="checkbox"/> <input type="radio"/> Abnormal craving for sweets or snacks                     |

**Neuromusculoskeletal:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> <input type="radio"/> Headaches            | <input type="checkbox"/> <input type="radio"/> Neck Pain            | <input type="checkbox"/> <input type="radio"/> Low back pain             |
| <input type="checkbox"/> <input type="radio"/> Upper extremity pain | <input type="checkbox"/> <input type="radio"/> Lower extremity pain | <input type="checkbox"/> <input type="radio"/> Tingling in hands or feet |

Please list any other serious medical condition(s) you have or ever had: \_\_\_\_\_

Please list anything that you may be allergic to: \_\_\_\_\_

Please list any previous surgeries/hospitalizations with dates: \_\_\_\_\_

Please list any **past** serious accidents with dates: \_\_\_\_\_

Do you currently take:  vitamins/supplements  prescription medications  over the counter medications

List: \_\_\_\_\_

Are you wearing  shoe lifts  inner soles  arch supports

**Health Promotion Survey:**

1. How are you sleeping? \_\_\_\_\_

2. How is your diet? \_\_\_\_\_

3. What is your exercise program? \_\_\_\_\_

4. What is the age of your mattress? \_\_\_\_\_ Is it still comfortable?  yes  no

5. Do you smoke?  no  yes How much? \_\_\_\_\_ How long? \_\_\_\_\_

6. What habits do you have that may be affecting your health?  
\_\_\_\_\_  
\_\_\_\_\_

7. What are your other stresses?  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_