HEALTH QUESTIONNAIRE

Name: _____ Date: _____

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

General:

☐ ○ Alcoholism
☐ ○ Anemia
☐ ○ Cancer
☐ ○ High cholesterol
☐ ○ Diabetes
☐ ○ Epilepsy/Seizures
☐ ○ Thyroid
☐ ○ Gout
☐ ○ Hypoglycemia
☐ ○ Multiple Sclerosis
☐ ○ Osteoarthritis
☐ ○ Parkinson's Disease
☐ ○ Pneumonia
☐ ○ Polio
☐ ○ Rheumatic Fever
☐ ○ Rheumatoid Arthritis
☐ ○ Depression
☐ ○ Tuberculosis
☐ ○ Ulcers
☐ ○ Venereal Disease
☐ ○ Skin problems

Resistance to Infection:

☐ ○ Catch colds easily
☐ ○ Frequent sinus trouble
☐ ○ Frequent Influenza

Gastrointestinal System:

☐ ○ Gall bladder probelm
☐ ○ Liver trouble/Hepatitis
☐ ○ Excessive thirst
☐ ○ Distress from greasy foods
☐ ○ Pain over stomach
☐ ○ Burping
☐ ○ Heartburn
☐ ○ Nausea
☐ ○ Diarrhea
☐ ○ Blood in stool
☐ ○ Metallic taste in mouth
☐ ○ Recent weight gain
☐ ○ Mucus in stool
☐ ○ Colitis
☐ ○ Hiatal Hernia
☐ ○ Vomiting
☐ ○ Constipation
☐ ○ Recent weight loss
☐ ○ Burning in stomach relieved by eating
☐ ○ Bloating (where? _____)

Cardiovascular System:

☐ ○ Pain over heart
☐ ○ Heart attack
☐ ○ Swelling in ankles
☐ ○ Irregular heart beat
☐ ○ Stroke
☐ ○ Pressure over chest
☐ ○ Low blood pressure
☐ ○ High blood pressure
☐ ○ Shortness of breath on exertion

Nervous System:

☐ ○ Dizziness/Lightheaded
☐ ○ Fainting
☐ ○ Discoordination
☐ ○ Memory loss

Eye, Ear, Nose and Throat:

☐ ○ Vision Problems
☐ ○ Hearing Loss
☐ ○ Ear Pain
☐ ○ Ear Noises
☐ ○ Dental Problems
☐ ○ Nose bleeds
☐ ○ Difficulty breathing through nose
☐ ○ Difficult speech
☐ ○ Hoarseness
☐ ○ Sore throat

Urinary Tract:

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

Respiratory Tract:

☐ ○ Chest Pain
☐ ○ Coughing up blood
☐ ○ Difficulty breathing
☐ ○ Shortness of breath
☐ ○ Allergies
☐ ○ Chronic cough
☐ ○ Spitting up phlegm
☐ ○ Emphysema
☐ ○ Asthma

PLEASE CONTINUE ON BACK

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

Women only:

☐ ○ Irregular periods ☐ ○ Headaches with period ☐ ○ Premenstrual depression
☐ ○ Hot flashes ☐ ○ Menstrual cramps ☐ ○ Painful breasts
☐ ○ Vaginal discharge ☐ ○ Excessive flow ☐ ○ Lumps in breasts
☐ ○ Menopausal symptoms ☐ ○ Hysterectomy

Men Only:

☐ ○ Burning on urination ☐ ○ Need to get up at night to urinate
☐ ○ Prostate trouble ☐ ○ Difficulty starting urine flow
☐ ○ Feeling of incomplete bowel evacuation ☐ ○ Dripping after urination

Blood Sugar:

☐ ○ Irritable before meals ☐ ○ Heart palpitates if meals are missed/delayed
☐ ○ Get "shaky" if hungry ☐ ○ Awaken after a few hours sleep, hard to get back to sleep
☐ ○ "Lightheaded if meals delayed ☐ ○ Moods of depression — "blues" or melancholy
☐ ○ Fatigue relieved by eating ☐ ○ Abnormal craving for sweets or snacks

Neuromusculoskeletal:

☐ ○ Headaches ☐ ○ Neck Pain ☐ ○ Low back pain
☐ ○ Upper extremity pain ☐ ○ Lower extremity pain ☐ ○ 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: _____