HEALTH QUESTIONAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.:_____

MUSCULO SKELETAL SYSTEM	GENTO-URINARY SYSTEM	GASTRO-INTESTIONAL SYSTEM	CARDIO-VASCULAR RESPIRATORY
□Low back pain	□Bladder trouble	□Poor appetite	□Chest pain
□Mid back pain	□Excessive urination	□Excessive hunger	□Pain over heart
□Pain between shoulders	□Scanty urination	□Difficult chewing	□Difficult breathing
□Neck pain	□Painful urination	□Difficult swallowing	□Persistent cough
□Arm problems	□Discolored urine	□Excessive thirst	□Coughing phlegm
□Leg problems		□Nausea	□Coughing blood
□Swollen joints	**FEMALE**	□Vomiting Blood	□Rapid heartbeat
□Painful joints		□Abdominal pain	□Blood pressure problem
□Stiff joints	□Vaginal discharge	□Diarrhea	□Heart problems
□Sore muscles	□Vaginal bleeding	□Constipation	□Lung problems
□Walking problems	□Vaginal pain	□Black stool	□Varicose veins
□Spasms	□Breast pain	□Bloody stool	
□Broken bones	□Lumps on the breast	□Hemorrhoids	**EYE, EAR, NOSE, AND THROAT**
□Shoulder pain		□Liver trouble	
	ARE YOU PREGNANT?	□Gall bladder problems	□Eye strain
	□ Yes □ No	□Weight trouble	□Eye inflammation
			□Vision problems
	HABITS	**NERVOUS SYSTEM**	□Ear pain
			□Ear noises
	□Cigarettes	□Numbness	□Ear discharge
	□Alcohol Abuse	□Loss of feeling	□Hearing loss
	□Coffee or Tea	□Paralysis	□Nose pain
	□Drug Abuse	□Dizziness	□Nose bleeding
	□_____	□Fainting	□Nose discharge
		□Headaches	□Difficult breathing through nose
		□Muscles jerking	□Sore gums
		□Convulsions	□Dental problems
		□Forgetfulness	□Sore mouth
		□Confusion	□Sore throat
		□Depression	□Hoarseness
		□Insomnia	□Difficult speech
			□Sinus
			□Allergy
			□Jaw pain

Patient's Signature: _____

----------DO NOT WRITE BELOW THIS LINE----------

_____

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_____

Patient Accepted? □Yes □No Doctor's Signature: _____