

Confidential Health Information Questionnaire

Name (last, first, initial) _____ Date _____
Birthdate _____ Age _____ Sex M F Height _____ Weight _____

Medical History

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prolonged Bleeder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Hernia | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Frequent Illness |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Visual Disturbance |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Circulation Problems |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other _____ |

List all hospitalizations for any medical illness or surgery. Please indicate reason and date: _____

List all medical tests you have had within the past few years _____

Are you currently or have you ever been treated for a heart or lung condition? Yes No

If yes, please explain (dates) _____

Do you have diabetes? Yes No Don't know Family history of: Yes No Don't know

If yes, controlled by: Diet Drugs Uncontrolled

Have you had a blood cholesterol test in the past 1-2 years? Yes No

If yes, results elevated? Not elevated?

Current Medical Status

What is the nature of your visit? _____

Are you pregnant? Yes No How many months? _____

Please list any medications you are taking: _____

Please list any medications you are allergic to: _____

Have you changed weight in the past year? Gained Lost Number of pounds _____

Do you think you are overweight? Yes No Are you on a diet? Yes No

Describe diet _____

Do you have difficulty sleeping at night? Yes No Time to bed _____ Time awake _____ # of hours of sleep _____

Briefly describe your physical level, include job description, and leisure activities _____

Do you have adverse reactions to heat or cold? Yes No Cardiac Pacemaker? Yes No

Metal implants (plates, screws, IUD)? Yes No Explain _____

Do you have any skin areas which are sensitive or lack sensation? Yes No Where? _____

Have you had a recent infection or dental surgery? Yes No When _____ Where? _____

Date _____ Patient Signature _____