# Confidential Health Information Questionnaire

Name (last, first, initial)____________________________________________Date______________
Birthdate________________ Age_________ Sex M F Height__________ Weight__________

**Medical History**

| | | |
|---|---|---|
| Anemia | Hypoglycemia | Liver Disease |
| Polio | Dizziness | Prolonged Bleeder |
| Cancer | Arthritis | Venereal Disease |
| Gout | Hernia | Nervous Disorder |
| Diabetes | Headaches | Frequent Illness |
| Phlebitis | Emphysema | Visual Disturbance |
| Shortness of Breath | Tuberculosis | Circulation Problems |
| Thyroid Problems | High Blood Pressure | Congestive Heart Failure |
| Heart Attack (MI) | Angina | 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______________________________________________