PATIENT QUESTIONNAIRE

PATIENT'S NAME _____ BIRTH DATE _____ SEX_____ STATUS: S.M.W.D

ADDRESS _____ CITY_____ ZIP_____ PHONE # _____

INSURANCE _____ REFERRED BY _____ OCCUPATION_____

INSTRUCTIONS: PUT "X" IN THOSE BOXES APPLICABLE TO YOU AND IN THE "YES" OR "NO" SPACE. IF LINES ARE PROVIDED WRITE IN YOUR ANSWER.

FAMILY HISTORY

			BROTHER(S)				SISTER(S)				GRANDPARENTS			
	FATHER	MOTHER	1	2	3	4	1	2	3	4	P-F	P-M	M-F	M-M
AGE (IF LIVING)														
HEALTH (G) GOOD (B) BAD														
CANCER														
TUBERCULOSIS														
DIABETES														
HEART DISEASE (HD) HEART ATTACK (HA)														
HIGH BLOOD PRESSURE														
STROKE														
EPILEPSY														
NERVOUS BREAKDOWN														
ASTHMA, HIVES, HAY FEVER														
BLOOD DISEASE														
AGE (AT DEATH)														
CAUSE OF DEATH														

PERSONAL HISTORY

HAVE YOU EVER HAD?	YES	NO	HAVE YOU EVER HAD? Past	Current	NO	HAVE YOU EVER HAD?	YES	NO
☐ SCARLET FEVER			☐ GONORRHEA ☐ SYPHILIS			☐ BROKEN BONE		
☐ DIPHTHERIA			☐ ANEMIA			☐ RECURRENT DISLOCATIONS		
☐ SMALLPOX			☐ JAUNDICE			☐ CONCUSSION ☐ HEAD INJURY		
☐ PNEUMONIA			☐ EPILEPSY			☐ BEEN KNOCKED UNCONSCIOUS		
☐ PLEURISY			☐ MIGRAINE HEADACHES			CAUSE : ☐ FOOD ☐CHEMICAL ☐DRUG POISONING		
			☐ TUBERCULOSIS			EXPLAIN		
☐ RHEUMATIC FEVER ☐ HEART DISEASE			☐ DIABETES					
			☐ CANCER					
☐ ARTHRITIS RHEUMATISM			☐ HIGH ☐ LOW BLOOD PRESSURE			ANY OTHER DISEASE		
ANY ☐ BONE ☐ JOINT DISEASE			☐ NERVOUS BREAKDOWN			EXPLAIN		
☐ NEURITIS ☐ NEURALGIA			☐ HAY FEVER ☐ASTHMA					
☐ BURSITIS ☐ SCIATICA ☐ LUMBAGO			☐ HIVES ☐ECZEMA					
☐ POLIO ☐ MENINGITIS			FREQUENT ☐ COLDS ☐SORE THROAT			WEIGHT: NOW ONE YR. AGO		
☐ APPENDICITIS			FREQUENT ☐ INFECTIONS ☐ BOILS			MAXIMUM WHEN		

ALLERGIES

ARE YOU ALLERGIC TO?	YES	NO	ARE YOU ALLERGIC TO?	YES	NO	ARE YOU ALLERGIC TO?	YES	NO
☐ PENICILLIN ☐ SULPHA DRUGS			ANY OTHER DRUGS			ANY FOODS		
☐ ASPIRIN ☐ CODEINE ☐ MORPHINE			EXPLAIN			EXPLAIN		
☐ MYCINS ☐ OTHER ANTIBIOTICS								
☐ TETANUS ANTITOXIN SERUMS			☐ ADHESIVE TAPE			☐ NAIL POLISH ☐ OTHER COSMETICS		

SURGERY

HAVE YOU HAD REMOVED?	YES	NO	HAVE YOU HAD REMOVED?	Current	NO	HAVE YOU?	YES	NO
TONSILS			☐ OVARY ☐ OVARIES			HAD HERNIA REPAIRED		
APPENDIX			HEMORRHOIDS			HAD ANY OTHER OPERATIONS		
GALL BLADDER			EVER HAVE A TRANSFUSION?			BEEN HOSPITALIZED FOR ANY ILLNESS		
UTERUS			BLOOD PLASMA			EXPLAIN		

X-RAYS

EVER HAVE X-RAYS OF?	YES	NO	DATE	DISEASE PRESENT
CHEST				
SPINE				
ABDOMEN				
OTHER				

SYSTEMS

DO YOU NOW HAVE OR HAVE YOU EVER HAD	YES	NO	DO YOU NOW HAVE OR HAVE YOU EVER HAD	YES	NO
ANY EYE ☐ DISEASE ☐ INJURY ☐ IMPAIRED SIGHT			KIDNEY ☐ DISEASE ☐ STONES		
ANY EAR ☐ DISEASE ☐ INJURY ☐ IMPAIRED HEARING			BLADDER DISEASE		
ANY TROUBLE WITH ☐ NOSE ☐ SINUSES ☐ MOUTH ☐ THROAT			IN URINE: ☐ BLOOD ☐ SUGAR ☐ PUS ☐ ETC		
FAINTING SPELLS			DIFFICULTY IN URINATION		
CONVULSIONS			# OF URINATIONS PER NIGHT _____		
PARALYSIS			NARROWED URINARY STREAM		
DIZZINESS			ABNORMAL THIRST		
HEADACHES ☐ FREQUENT ☐ SEVERE			PROSTATE TROUBLE		
ENLARGED GLANDS			☐ STOMACH TROUBLE ☐ ULCER		
THYROID: ☐ OVERACTIVE ☐ UNDERACTIVE ☐ ENLARGED			INDIGESTION		
☐ GOITER			☐ GAS ☐ BELCHING		
SKIN DISEASE			☐ LIVER DISEASE ☐ GALL BLADDER DISEASE		
COUGH ☐ FREQUENT ☐ CHRONIC			☐ COLITIS ☐ OTHER BOWEL DISEASE		
☐ CHEST PAIN ☐ ANGINA PECTORIS			☐ HEMORRHOIDS ☐ RECTAL BLEEDING		
SPITTING UP BLOOD			BLACK TARRY STOOLS		
NIGHT SWEATS			☐ CONSTIPATION ☐ DIARRHEA		
SHORTNESS OF BREATH ☐ EXERTION ☐ AT NIGHT			☐ PARASITES ☐ WORMS		
☐ PALPITATION ☐ FLUTTERING HEART			☐ ANY CHANGE IN APPETITE ☐ EATING HABITS		
SWELLING OF ☐ HANDS ☐ FEET ☐ ANKLES			☐ ANY CHANGE IN BOWEL ACTION ☐ STOOLS		
VARICOSE VEINS			EXPLAIN:		
EXTREME ☐ TIREDNESS ☐ WEAKNESS					

IMMUNIZATION

HAVE YOU HAD	YES	NO
ANY VACCINATIONS WITHIN THE LAST 10 YEARS		
TETANUS SHOT (NOT ANTITOXIN) WITHIN THE LAST 8 YEARS		

EKG

HAVE YOU HAD	YES	NO
AN ELECTROCARDIOGRAM - WHEN		

HABITS

DO YOU	YES	NO	DO YOU USE	NEVER	OCC	FREQ	DAILY
EXERCISE ADEQUATELY			LAXATIVES				
HOW?			VITAMINS				
AWAKEN RESTED			SEDATIVES				
SLEEP WELL			TRANQUILIZERS				
AVERAGE 8 HOURS SLEEP (PER NIGHT)			SLEEP MEDICATION				
HAVE REGULAR BOWEL MOVEMENTS			ASPIRIN, IBUPROFEN				
SEX - ENTIRELY SATISFACTORY			CORTISONE				
LIKE YOUR WORK (HRS/DAY) ☐ INDOORS ☐ OUTDOORS			ALCOHOLIC DRINKS (PER WEEK)				
WATCH TELEVEISION (HOURS PER DAY)			COFFEE (CUPS PER DAY)				
READ (HOURS PER DAY)			TOBACCO CIGARETTES (CIGS PER DAY)				
HAVE A VACATION (WEEKS PER YEAR)			SWEET TREATS				
HAVE YOU EVER BEEN TREATED FOR ALCOHOLISM			APPETITE DEPRESSANTS				
HAVE YOU EVER BEEN TREATED FOR DRUG ABUSE			THYROID MEDICATION: ☐ CURRENT ☐ PAST DOSE _____				
PARTICIPATE IN SPORTS OR HAVE HOBBIES WHICH GIVE YOU RELAXATION AT LEAST 3 HOURS A WEEK			HAVE YOU EVER TAKEN ☐ INSULIN ☐ TABLETS FOR DIABETES ☐ HORMONE SHOTS ☐ TABLETS ☐ NO				

EMOTIONS

ARE YOU OFTEN	YES	NO	ARE YOU OFTEN	YES	NO
DEPRESSED			JUMPY		
ANXIOUS			JITTERY		
IRRITABLE			IS CONCENTRATION DIFFICULT?		

WOMEN ONLY

MENSTRUAL HISTORY

AGE AT ONSET _____			ARE YOU REGULAR: HEAVY MEDIUM LIGHT		
USUAL DURATION OF PERIOD (_____DAYS)			BEFORE PERIOD DO YOU HAVE: ☐ PMS ☐ BLUES ☐ BREAST TENDERNESS		
CYCLE (START TO START) (_____DAYS)			DO YOU HAVE CRAMPS		
DATE OF LAST PERIOD _____			DO YOU HAVE ☐ HOT FLASHES ☐ NIGHT SWEATS		

PREGNANCIES

CHILDREN HOW MANY_____	MISCARRIAGES (HOW MANY_____)	PREMATURES (HOW MANY)

Medications

Name _____ Dose_____ Frequency_____

Name _____ Dose_____ Frequency_____

Name _____ Dose_____ Frequency_____

Name _____ Dose_____ Frequency_____

Supplements

Name _____ Dose_____ Frequency_____

Name _____ Dose_____ Frequency_____

Name _____ Dose_____ Frequency_____

Name _____ Dose_____ Frequency_____