

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														
	FATHER	MOTHER	BROTHER(S)				SISTER(S)				GRANDPARENTS			
			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
<input type="checkbox"/> SCARLET FEVER			<input type="checkbox"/> GONORRHEA <input type="checkbox"/> SYPHILIS				<input type="checkbox"/> BROKEN BONE		
<input type="checkbox"/> DIPHTHERIA			<input type="checkbox"/> ANEMIA				<input type="checkbox"/> RECURRENT DISLOCATIONS		
<input type="checkbox"/> SMALLPOX			<input type="checkbox"/> JAUNDICE				<input type="checkbox"/> CONCUSSION <input type="checkbox"/> HEAD INJURY		
<input type="checkbox"/> PNEUMONIA			<input type="checkbox"/> EPILEPSY				<input type="checkbox"/> BEEN KNOCKED UNCONSCIOUS		
<input type="checkbox"/> PLEURISY			<input type="checkbox"/> MIGRAINE HEADACHES				POISONING CAUSE: <input type="checkbox"/> FOOD <input type="checkbox"/> CHEMICAL <input type="checkbox"/> DRUG		
			<input type="checkbox"/> TUBERCULOSIS				EXPLAIN		
<input type="checkbox"/> RHEUMATIC FEVER <input type="checkbox"/> HEART DISEASE			<input type="checkbox"/> DIABETES						
			<input type="checkbox"/> CANCER						
<input type="checkbox"/> ARTHRITIS RHEUMATISM			<input type="checkbox"/> HIGH <input type="checkbox"/> LOW BLOOD PRESSURE				ANY OTHER DISEASE		
ANY <input type="checkbox"/> BONE <input type="checkbox"/> JOINT DISEASE			<input type="checkbox"/> NERVOUS BREAKDOWN				EXPLAIN		
<input type="checkbox"/> NEURITIS <input type="checkbox"/> NEURALGIA			<input type="checkbox"/> HAY FEVER <input type="checkbox"/> ASTHMA						
<input type="checkbox"/> BURSITIS <input type="checkbox"/> SCIATICA <input type="checkbox"/> LUMBAGO			<input type="checkbox"/> HIVES <input type="checkbox"/> ECZEMA						
<input type="checkbox"/> POLIO <input type="checkbox"/> MENINGITIS			FREQUENT <input type="checkbox"/> COLDS <input type="checkbox"/> SORE THROAT				WEIGHT: NOW ONE YR. AGO		
<input type="checkbox"/> APPENDICITIS			FREQUENT <input type="checkbox"/> INFECTIONS <input type="checkbox"/> BOILS				MAXIMUM WHEN		

ALLERGIES									
ARE YOU ALLERGIC TO?	YES	NO	ARE YOU ALLERGIC TO?	YES	NO	ARE YOU ALLERGIC TO?	YES	NO	
<input type="checkbox"/> PENICILLIN <input type="checkbox"/> SULPHA DRUGS			ANY OTHER DRUGS			ANY FOODS			
<input type="checkbox"/> ASPIRIN <input type="checkbox"/> CODEINE <input type="checkbox"/> MORPHINE			EXPLAIN			EXPLAIN			
<input type="checkbox"/> MYCINS <input type="checkbox"/> OTHER ANTIBIOTICS									
<input type="checkbox"/> TETANUS ANTITOXIN SERUMS			<input type="checkbox"/> ADHESIVE TAPE			<input type="checkbox"/> NAIL POLISH <input type="checkbox"/> OTHER COSMETICS			

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

IMMUNIZATION			EKG		
HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO
ANY VACCINATIONS WITHIN THE LAST 10 YEARS			AN ELECTROCARDIOGRAM - WHEN		
TETANUS SHOT (NOT ANTITOXIN) WITHIN THE LAST 8 YEARS					

HABITS						
DO YOU	YES	NO	DO YOU USE	NEVER	OCC	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) <input type="checkbox"/> INDOORS <input type="checkbox"/> OUTDOORS			ALCOHOLIC DRINKS (PER WEEK)			
WATCH TELEVISION (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: <input type="checkbox"/> CURRENT <input type="checkbox"/> PAST DOSE _____			
PARTICIPATE IN SPORTS OR HAVE HOBBIES WHICH GIVE YOU RELAXATION AT LEAST 3 HOURS A WEEK			HAVE YOU EVER TAKEN			
			<input type="checkbox"/> INSULIN <input type="checkbox"/> TABLETS FOR DIABETES <input type="checkbox"/> HORMONE SHOTS <input type="checkbox"/> TABLETS <input type="checkbox"/> 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: <input type="checkbox"/> PMS <input type="checkbox"/> BLUES <input type="checkbox"/> BREAST TENDERNESS		
CYCLE (START TO START) (_____ DAYS)			DO YOU HAVE CRAMPS		
DATE OF LAST PERIOD _____			DO YOU HAVE <input type="checkbox"/> HOT FLASHES <input type="checkbox"/> 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 _____