Health History Questionnaire

INSTRUCTIONS:

Please circle the most appropriate answer.

Patient Name ___________________________________

Date ____ / ____ / _____ Acct # _______ Score ________

A

1	Do you need glasses to read?	YES	NO
2	Do you need glasses to see things at a distance?	YES	NO
3	Has your eyesight often blacked out completely?	YES	NO
4	Do your eyes continually blink or water?	YES	NO
5	Do you often have bad pains in your eyes?	YES	NO
6	Are your eyes often red or inflamed?	YES	NO
7	Are you hard of hearing?	YES	NO
8	Have you ever had a draining ear?	YES	NO
9	Do you have constant noises in your ears?	YES	NO

B

10	Do you have to clear your throat frequently?	YES	NO
11	Do you often feel a choking lump in your throat?	YES	NO
12	Are you often troubled with bad spells of sneezing?	YES	NO
13	Is your nose continually stuffed up?	YES	NO
14	Do you suffer from a constantly running nose?	YES	NO
15	Have you at times had bad nose bleeds?	YES	NO
16	Do you often catch severe colds?	YES	NO
17	Do you frequently suffer from heavy chest colds?	YES	NO
18	Do you frequently go to bed when you have a cold?	YES	NO
19	Do frequent colds keep you miserable during the year?	YES	NO
20	Do you get hay fever?	YES	NO
21	Do you suffer from asthma?	YES	NO
22	Are you troubled by constant coughing?	YES	NO
23	Do you frequently cough up blood?	YES	NO
24	Do you sometimes have severe soaking sweats at night?	YES	NO
25	Have you ever had a chronic chest condition?	YES	NO
26	Have you ever had T.B. (Tuberculosis)?	YES	NO
27	Did you ever live with anyone who had T.B.?	YES	NO

C

28	Has a doctor ever said your blood pressure was too high?	YES	NO
29	Has a doctor ever said your blood pressure was too low?	YES	NO
30	Do you have pains in the heart or chest?	YES	NO
31	Are you often bothered by thumping of the heart?	YES	NO
32	Do you often have a rapid heart rate?	YES	NO
33	Do you often have difficulty in breathing?	YES	NO
34	Do you get out of breath easily?	YES	NO
35	Do you sometimes get out of breath just sitting still?	YES	NO
36	Are your ankles often swollen?	YES	NO
37	Do cold hands or feet trouble you even in hot weather?	YES	NO
38	Do you suffer from frequent cramps in your legs?	YES	NO
39	Has a doctor ever said you had heart trouble?	YES	NO
40	Does heart trouble run in your family?	YES	NO

D

41	Have you lost more than half your teeth?	YES	NO
42	Are you troubled by bleeding gums?	YES	NO
43	Have you often had severe toothaches?	YES	NO
44	Is your tongue usually badly coated?	YES	NO
45	Do you frequently have a poor appetite?	YES	NO
46	Do you usually eat sweets or other food between meals?	YES	NO
47	Do you gulp your food in a hurry'?	YES	NO
48	Do you often suffer from an upset stomach?	YES	NO
49	Do you usually feel bloated after eating?	YES	NO
50	Do you usually belch a lot after eating?	YES	NO
51	Are you often sick to your stomach?	YES	NO
52	Do you suffer from indigestion?	YES	NO
53	Do severe pains in the stomach often double you up?	YES	NO
54	Do you suffer from constant stomach trouble?	YES	NO
55	Does stomach trouble run in your family?	YES	NO
56	Has a doctor ever said you had stomach ulcers?	YES	NO
57	Do you suffer from frequently loose bowel movements?	YES	NO
58	Have you ever had bloody diarrhea?	YES	NO
59	Were you ever troubled with intestinal parasites?	YES	NO
60	Do you frequently suffer from constipation?	YES	NO
61	Have you ever had hemorrhoids?	YES	NO
62	Have you ever had jaundice (yellow eyes and skin)?	YES	NO
63	Have you ever had serious liver or gall bladder trouble?	YES	NO

E

64	Are your joints often painfully swollen?	YES	NO
65	Do your muscles and joints frequently feel stiff?	YES	NO
66	Do you usually have severe pains in the arms or legs?	YES	NO
67	Are you debilitated with severe arthritis?	YES	NO
68	Does arthritis run in your family?	YES	NO
69	Do weak or painful feet make your life miserable?	YES	NO
70	Does back pain make it difficult to get through your day?	YES	NO
71	Are you troubled with a serious disability or deformity?	YES	NO

F

72	Is your skin very sensitive or tender?	YES	NO
73	Do cuts and bruises heal slowly?	YES	NO
74	Does your face often get badly flushed?	YES	NO
75	Do you sweat a great deal even in cold weather?	YES	NO
76	Are you often bothered by severe itching?	YES	NO

77 Does your skin often break out in a rash? YES NO

78 Are you often troubled with acne or boils? YES NO

G

79 Do you suffer from frequent headaches? YES NO

80 Does pressure in the head often make life miserable? YES NO

81 Are headaches common in your family? YES NO

82 Do you have hot or cold spells? YES NO

83 Do you often have spells of dizziness? YES NO

84 Do you frequently feel faint? YES NO

85 Have you fainted more than twice in your life? YES NO

86 Do you have numbness or tingling in any body part? YES NO

87 Was any part of your body ever paralyzed? YES NO

88 Were you ever knocked unconscious? YES NO

89 Have you at times had a twitching of the face or head? YES NO

90 Did you ever have convulsions or seizures? YES NO

91 Has anyone in your family had convulsions or seizures? YES NO

92 Did you ever bite your nails badly? YES NO

93 Have you ever been troubled by stuttering or stammering? YES NO

94 Are you a sleep walker? YES NO

95 Are you currently a bed wetter? YES NO

96 Were you a bed wetter as a child? YES NO

H – FEMALE ONLY

97 Were or are your menstrual periods usually painful? YES NO

98 Have you often felt weak or sick with your periods? YES NO

99 Have you often had to lie down during your period? YES NO

100 Are you usually tense or jumpy with your periods? YES NO

101 Do you have frequent hot flashes and sweats? YES NO

102 Have you often been troubled with vaginal discharge? YES NO

103 Do you frequently get up at night to urinate? YES NO

104 During the day, do you have to urinate frequently? YES NO

105 Do you often have burning pain when you urinate? YES NO

106 Do you sometimes lose control of your bladder? YES NO

107 Have you ever had kidney or bladder disease? YES NO

H – MALE ONLY

108 Have you ever had a health problem with your genitals? YES NO

109 Are your genitals often painful or swollen? YES NO

110 Have you ever had treatment for your genitals? YES NO

111 Have you ever had an inguinal hernia? YES NO

112 Have you ever passed blood while urinating? YES NO

113 Do you have difficult or slow urination? YES NO

114 Do you frequently get up at night to urinate? YES NO

115 During the day, do you urinate frequently? YES NO

116 Do you often have burning while urinating? YES NO

117 Do you sometimes lose control of your bladder? YES NO

118 Have you ever had kidney or bladder disease? YES NO

I

119 Do you often feel completely exhausted or fatigued? YES NO

120 Does working tire you out completely? YES NO

121 Do you usually wake up tired and exhausted? YES NO

122 Does every little effort wear you out? YES NO

123 Are you frequently too tired and exhausted to eat? YES NO

124 Do you suffer from frequent nervous exhaustion? YES NO

125 Does nervous exhaustion run in your family? YES NO

J

126 Are you frequently ill? YES NO

127 Are you frequently confined to bed by illness? YES NO

128 Are you frequently in poor health? YES NO

129 Are you considered a sickly person? YES NO

130 Do you come from a sickly family? YES NO

131 Do aches and pains make it difficult to work? YES NO

132 Do you wear yourself out worrying about your health? YES NO

133 Are you frequently depressed and unhappy? YES NO

134 Do you feel over whelmed due to poor health? YES NO

K

135 Did you ever have scarlet fever? YES NO

136 Have you had rheumatic fever or growing pains? YES NO

137 Did you ever have malaria? YES NO

138 Were you ever treated for anemia? YES NO

139 Have you been treated for a sexually transmitted disease? YES NO

140 Do you have diabetes? YES NO

141 Did a doctor ever say you had a goiter? YES NO

142 Have you ever been treated for a tumor or cancer? YES NO

143 Did you suffer from any chronic disease? YES NO

144 Are you definitely under weight? YES NO

145 Are you definitely over weight? YES NO

146 Do you have varicose veins in your legs? YES NO

147 Have you ever had surgery? YES NO

148 Did you ever have a serious injury? YES NO

149 Do you often have small accidents or injuries? YES NO

L

150 Do you have difficulty falling asleep or staying asleep? YES NO

151 Do you find it impossible to take a rest break daily? YES NO

152 Do you find it impossible to exercise daily? YES NO

153 Have you ever or do you smoke tobacco? YES NO

154 Do you frequently drink coffee or tea? YES NO

155 Do you frequently drink alcohol? YES NO