This questionnaire will help us find out more about your health and your health history at your scheduled appointment. These topics will be discussed in more detail at your appointment. Follow instructions and be brief in your answers.

Name: _____ Age: _____ Date: _____

What is the main problem that brings you to see us today?

Have you already had testing done to evaluate this problem? No ☐ Yes ☐

If yes, who was your provider?

Where?

Have you had any x-rays done to evaluate this problem? No ☐ Yes ☐

Where? When?

Have you been to the emergency room to evaluate this problem? No ☐ Yes ☐

Where? When?

Have you had lab work done to evaluate this problem? No ☐ Yes ☐

Where? When?

PLEASE MARK ALL THAT APPLY
(Add additional information if needed)

CONSTITUTIONAL

[ ] Weight Loss
High school weight_____ lbs.
[ ] Fatigue
[ ] Fever
[ ] Night Sweats

EYES

[ ] Eye Pain
[ ] Eye Swelling
[ ] Double Vision
[ ] Cataracts

EAR – NOSE - THROAT

[ ] Difficulty hearing
[ ] Ringing in Ears
[ ] Vertigo
[ ] Sinus Trouble

CARDIOVASCULAR

[ ] Heart Murmur
[ ] Chest pain
[ ] Palpitations
[ ] Dizziness
[ ] Fainting Spells
[ ] Shortness of Breath
[ ] Difficulty lying flat
[ ] Swelling in Ankles

RESPIRATORY

[ ] Cough
[ ] Coughing Blood
[ ] Wheezing
[ ] Chills
[ ] History of Tuberculosis

URINARY

[ ] Burning
[ ] Frequent Urination
[ ] Blood in Urine
[ ] Leaking Urine

GASTROINTESTINAL

[ ] Trouble Swallowing (food sticking)
[ ] Heartburn
[ ] Nausea
[ ] Vomiting
[ ] Constipation
[| Change in Bowel Movements
[ ] Diarrhea
[ ] Abdominal Pain
[ ] Black or Bloody Stool
[ ] Jaundice

PSYCHIATRIC

[ ] Anxiety
[ ] Depression
[ ] Trouble Sleeping
[ ] Hospitalized for psychiatric problems

BLOOD DISORDERS

[ ] Anemia
[ ] Gums bleed easily

MUSCULOSKELETAL

[ ] Joint pain / Swelling
[ ] Muscle Pain
[ ] Back Pain
[ ] Stiffness

SKIN

[ ] Rash / Sores
[ ] Painful red nodules
[ ] Red Palms

ALLERGIES

[ ] Hay fever
[ ] Eczema
[ ] Seasonal Allergies

NEUROLOGICAL

[ ] Headaches
[ ] Seizures
[ ] Memory Loss
[ ] Weakness

FEMALES ONLY

Of Pregnancies _____
Of Live Births _____
[ ] Infertility
[ ] Heavy Menstrual Cycle