

Health History Questionnaire

Significant past medical history: Please indicate approximate dates of any serious illnesses and/or surgeries for the categories below:

Surgical History

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> C-section	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Cataract surgery	<input type="checkbox"/> Heart surgery	<input type="checkbox"/> Brain surgery
<input type="checkbox"/> Gallbladder surgery	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Cosmetic surgery
<input type="checkbox"/> Spinal surgery	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Prostate surgery

Other: _____

General Health

<input type="checkbox"/> Hip replacement	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Knee replacement	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Biopsy (site)
<input type="checkbox"/> Allergies	<input type="checkbox"/> Headache	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Back pain	<input type="checkbox"/> Stroke	<input type="checkbox"/> Cancer
<input type="checkbox"/> Depression	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Tia's
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Hernia repair
<input type="checkbox"/> Joint repair	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Head injury	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Seizures	<input type="checkbox"/> Tremors	<input type="checkbox"/> Ulcers

Other: _____

Family History

Were your parents or siblings treated for any of the above named conditions?

Father: _____

Mother: _____

Brother: _____

Sister: _____

Health History Questionnaire

Review of Systems

GENERAL

- Weight changes
- Poor appetite
- Tiredness
- Fever or chills

HEAD & NECK

- Neck pains
- Sores in the mouth
- Headaches

EYES

- Loss of vision
- Double vision
- Blurring of vision
- Aversion to light
- Pain

ENT

- Hearing difficulty
- Ringing in the ears
- Earaches
- Allergies

HEART

- Palpitations
- Chest pain
- Sleeping upright to breathe
- Swelling in feet or ankles
- Fainting

LUNGS

- Wheezes
- Coughing
- Coughing up blood
- Shortness of breath

DIGESTION

- Heartburn
- Nausea/vomiting
- Difficulty swallowing

MUSCULOSKELETAL

- Bone or joint pain
- Joint stiffness & swelling
- Muscle tenderness
- Back pains

HEART

- Palpitations
- Chest pain
- Sleeping upright to breathe
- Swelling in feet or ankles

NEUROLOGICAL

- Seizures
- Loss of consciousness
- Loss of balance
- Numbness
- Loss of memory
- Speech problems

ENDOCRINE

- Excessive sweating
- Excessive thirst
- Excessive hunger

GENITOURINARY

- Frequent urination at night
- Brown or bloody urine
- Difficulty starting to urinate
- Impotence

PSYCHIATRIC

- Anxiety
- Depression

SKIN

- Rash
- Easy bruising

OTHER
