USA HEALTH &THERAPY

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HEALTH QUESTIONNAIRE

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time to answer each questions as completely as possible. Please sign each page.

PATIENT INFORMATION

Today's Date ______________________________ Date of Incident _______________________

Mr/Mrs/Miss/Ms:______ First Name:_________________________ Last Name:___________________________

Address: _________________________ Apt#_____ City/State:___________________________ Zip:__________

Home________________ Cell Phone_______________ D.O.B_______ Age ____ Soc.Sec.#__________________

Occupation:_______________________ Employer:__________________ Work Phone #:_____________________

Marital Status: Married/Partner/Divorced/Widowed/Single (circle one) Number of Children:____

Spouse's Name:______________________ Employer:__________________ Work Phone #:___________________

Family Physician:_____________________________________ Phone Number:_____________________________

Your Health Ins. Co:__________________________________ Policy Number:____________________________

Email Address:____

Referred By:____

HEALTH INFORMATION*

What Are Your Chief Complaints For Which You Are Seeking Treatment?
(In order of importance with 1 being the most important)

1.______________________________ 2.______________________________ 3.______________________________

4.______________________________ 5.______________________________ 6.______________________________

7.______________________________ 8.______________________________ 9.______________________________

Describe The Incident For Which You Are Seeking Treatment.____

MEDICAL HISTORY

Are You Allergic To Any Medicines? Yes/No (circle one) If Yes, What Medicine?__________________________

Are You Taking Any Medicines? Yes/No (circle one)

What Medicines Are You Taking? 1. _________________________ 2. _________________________

3. _________________________ 4. _________________________

5. _________________________ 6. _________________________

Have You Been Hospitalized In The Past Five Years? Yes/No (circle one)

Date And Reason____

Have You Had **ANY** Surgery In The Past Five Years? Yes/No (circle one)

Date And Reason ____

Have You Had **ANY** Other Serious Accidents? Yes/No (circle one)

Date And Describe ____

Females**:** Are you pregnant or do you think you could be pregnant Yes/No (circle one)

List Any Treatments And Health Professionals You Are Currently Seeing For This Problem:

PHYSICIAN	SPECIALTY	TREATMENT & DATE
1.		
2.		
3.		
4.		

Signature X_________________________________ **Date** _______________________________

CHECK THE FOLLOWING CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST

Allergies:_____
Hay Fever
Cirrhosis
Hepatitis
Liver Disease
Lung Disease
Asthma
Chronic Colds
Emphysema
Tuberculosis
Shortness of Breath
Frequent Cough
Cancer:_____
Pneumonia
Diabetes
Bloating
Gallbladder Problems
Colitis
Arthritis
Osteoarthristis
Rheumatoid
Sugar in Urine
Urinary Tract Infection
Blood in Urine
Kidney Disease
Cerebral Palsy
Epilepsy
Neuralgia
Multiple Sclerosis
Appendicitis
Tonsillitis
Bronchitis
Thyroid Problems
Prostate Problems
Hernia
Constipation
Anemia
HIV Positive
AIDS
Bleeding Easily
Hemophilia
Leukemia
Muscle Dystrophy
Muscle Shaking (tremors)
Muscle Spasms or Cramps
Rheumatic Fever
Anorexia/Bulimia
Alcoholism
Glaucoma
Cataracts
Psychiatric Care
Suicide Attempt
Chemical Dependency
Frequent Diarrhea
Heart Valve
Arteriosclerosis
Heart Murmur
Heart Palpitations
High Blood Pressure
Low Blood Pressure
Poor Circulation
Heart Pacemaker
Ulcers/Heartburn
High Cholesterol
Stroke
Migraine Headaches
Venereal Disease
Mononucleosis
Goiter
Gout
Epilepsy
Joint Replacement

CHECK THE FOLLOWING SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST

GENERAL
Anxiety
Chills
Depression
Dizziness
Fainting
Fever
Fatigue
Headache
Loss of sleep
Nervousness
Forgetfulness

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:

Arms
Hips
Back
Legs
Feet
Neck
Hands
Shoulders

GASTROINTESTINAL
Appetite poor
Bloating
Bowel changes
Constipation
Diarrhea
Excessive hunger
Excessive thirst
Excessive gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach pain
Vomiting
Vomiting blood

CARDIOVASCULAR
Chest pain
High blood pressure
Irregular heart beat
Low blood pressure
Poor circulation
Rapid heart beat
Swelling of ankles
Varicose veins

EYE/EAR/NOSE/THROAT
Bleeding gums
Blurred vision
Difficulty-swallowing
Double vision
Earache
Ear discharge
Hay fever
Hoarseness
Loss of hearing
Nosebleeds
Persistent cough
Ringing in ears
Sinus problems
Vision-Flashes
Vision-Halos

SKIN
Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sore that won't heal
Texture changes

MEN ONLY
Breast lump
Erection difficulties
Lump in testicles
Penis discharge
Sore on penis
Other _____

WOMEN ONLY

Abnormal pap smear
Bleeding between periods
Breast lump
Extreme menstrual pain
Hot flashes
Nipple discharge
Vaginal discharge
Painful intercourse
Other_____

GENITOURINAY
Blood in urine
Frequent urination
Lack of bladder control
Painful urination

Signature X_____ **Date** _____