HEALTH QUESTIONNAIRE

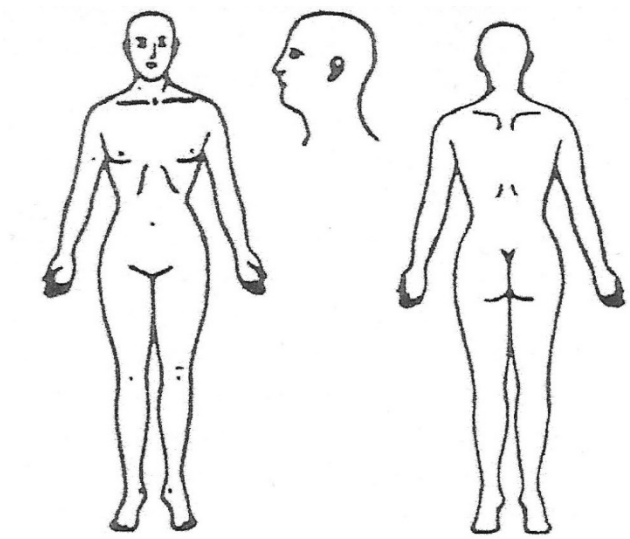
PATIENT NAME: _____ DATE: _____

Please indicate if you have experienced any of the following by using

1 for **Presently have** and **2** for **Previously had**

	MUSCULO-SKELETAL SYSTEM		**GASTRO-INTESTINAL SYSTEM**		**CARDIO-VASCULAR-RESPIRATORY**
	Low back problems		Poor appetite		Chest pain
	Pain between shoulders		Excessive hunger		Difficult breathing
	Neck problems		Difficult chewing		Persistent cough
	Arm problems		Difficult swallowing		Coughing phlegm
	Leg problems		Excessive thirst		Coughing blood
	Swollen joints		Nausea		Rapid heartbeat
	Painful joints		Vomiting food		Blood pressure problems
	Stiff joints		Vomiting blood		Heart problems
	Sore muscles		Abdominal pain		Lung problems
	Weak muscles		Diarrhea		Varicose veins
	Walking problems		Constipation		
	Ruptures		Black Stool		**EYE, EAR, NOSE AND THROAT**
	Broken Bones		Bloody stool		Eye strain
			Hemorrhoids		Eye inflammation
	GENITO-URINARY SYSTEM		Liver Trouble		Vision Problems
	Bladder trouble		Gall bladder problems		Ear pain
	Excessive urine		Weight trouble		Ear noises
	Scanty urination				Hearing loss
	Painful urination		**NERVOUS SYSTEM**		Ear Discharge
	Discolored urine		Numbness		Nose pain
			Paralysis		Nose bleeding
	FEMALE		Dizziness		Nose discharge
	Vaginal discharge		Fainting		Difficult breathing thru nose
	Vaginal bleed		Headaches		Sore gums
	Vaginal pain		Muscle jerking		Dental problems
	Breast pain		Convulsions		Sore mouth
	Lumps on Breast		Forgetfulness		Hoarseness
			Confusion		Difficult speech
			Depression		

<u>Please mark</u> your areas of pain on the figures shown below.



Childhood Diseases: _____

_____

Complications: _____

_____

Prior Surgery: _____

_____

Medication presently taking: _____

_____

Previous Accidents: _____

_____

Mother Living? YES / NO **In good health?** YES / NO

Father Living? YES / NO **In good health?** YES / NO