

**MEDICAL HISTORY QUESTIONNAIRE**

NAME: \_\_\_\_\_  
DOB: \_\_\_\_\_  
HEIGHT: \_\_\_\_\_  
DO YOU LIVE ALONE? YES/NO  
# OF CHILDREN & AGES

DATE: \_\_\_\_\_  
MARITAL STATUS: \_\_\_\_\_  
WEIGHT: \_\_\_\_\_  
CURRENTLY WORKING? YES/NO  
OCCUPATION: \_\_\_\_\_

PLEASE CHECK IF YOU ARE PRESENTLY  
TROUBLED BY A PARTICULAR SYMPTOM

MEDICAL HISTORY (PLEASE CIRCLE  
ONE IF APPROPRIATE)

- CHEST PAIN
- NECK PAIN
- SHOULDER PAIN
- PAIN IN UPPER ARM OR ELBOW
- HAND PAIN
- UPPER BACK PAIN
- LOW BACK PAIN
- PAIN IN UPPER LEG OR HIP
- PAIN IN LOWER LEG OR KNEE
- PAIN IN ANKLE OR FOOT
- JAW PAIN
- SWELLING OR STIFFNESS OF JOINT
- FAINTING, VISUAL DISTURBANCES, NAUSEA
- DIZZINESS
- HEADACHE
- MUSCULAR INCORDINATION
- TINNITUS (EAR NOISE)
- GENERAL FATIGUE

- PAST/PRESENT AORTIC ANEURYSM
- PAST/PRESENT HIGH BLOOD PRESSURE
- PAST/PRESENT HEART ATTACK
- PAST/PRESENT STROKE
- PAST/PRESENT ASTHMA/LUNG DISORDER
- PAST/PRESENT CANCER
- PAST/PRESENT PROSTATE PROBLEMS
- PAST/PRESENT BLOOD DISORDERS
- PAST/PRESENT THYROID DISORDERS
- PAST/PRESENT DIABETES
- PAST/PRESENT

OTHER: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ALL SURGERIES YOU HAVE  
HAD AND WHAT YEAR:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE  
CURRENTLY TAKING:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST HOBBIES/ACTIVITIES:

