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COMPREHENSIVE MEDICAL QUESTIONAIRE

NAME:_____DATE:_____AGE:____
PLACE OF BIRTH:_____OCUPATION:_____
DOCTORS, HEALTH PRACTIONERS, THERAPISTS, ACUPUNCTURISTS YOU SEE: _____
_____
MEDICATIONS:_____
ALLERGIES TO MEDICATIONS:_____
SUPPLEMENTS:_____
SURGERIES:_____
INJURIES:_____
BLOOD TYPE?_____DON'T KNOW_____PAST MEDICAL ILLNESSES:_____
_____
HEPATITIS___HIV___HERPES___GENITAL WARTS___SYPHILIS___CHALYMIDIA__PID___
(PELVIC INFLAMMATORY DISEASE), GONNORRHEA___LVG---BV---OTHERS:_____

HEALTH HABITS

DID/DO YOU SMOKE?___CIGARETTES___OTHER_____PACKS/DAY___HOW LONG___
DID/DO YOU DRINK CAFFEINATED BEVERAGES?___WHAT_____CUPS/DAY___
DID/DO YOU DRINK ALCOHOL?___HOW MUCH:___HOW OFTEN:____WHAT_____
DID/DO YOU EXERCISE?___HOW OFTEN_____WHAT TYPE_____
DIETARY RESTRICTIONS, VEGETARIAN, FOOD ALLERGIES?___WHAT_____
HOW OFTEN DO YOU EAT SUGAR?___SALT:___FAT___FAST FOOD___WHAT_____

FAMILY HISTORY

IF DECEASED PLEASE MARK AGE AT DEATH, AGE OF MOTHER:___ FATHER____SIB___
HAVE ANY OF YOUR RELATIVES HAD THE FOLLOWING? WHO?:
ALLERGIES/ASTHMA:_____
ARTHRITIS:_____
BLEEDINGPROBLEMS:_____
CANCER:_____
COPD, EMPHSEMA, LUNG DISEASE:_____
DEPRESSION, NERVOUS DISORDERS,MENTAL ILLNESS:_____
DIABETES:_____
EPILEPSY/CONVULSIONS:_____
GLAUCOMA, MACULAR DEGENERATION, BLINDNESS:_____
HEART DISEASE:_____
HEARTBURN/GASTRITIS:_____
HIGH BLOOD PRESSURE_____
HYPERLIPIDEMIA:_____
KIDNEY DISEASE:_____
OSTEOPOROSIS:_____
STROKE:_____
TUBERCULOSIS:_____
OTHER:_____
Do you remember your dreams? What are they like and what do they mean to you?_____
Do you have spiritual ro religious beliefs or practices? If so what are they ? What role do they

play in your life?_____
Do you get emotional support? From where or whom?_____

FOR WOMEN ONLY:

Age of onset of first menses_____ Are your periods regular?_____
Length of time between cycles_____ How many days do you bleed?
No. of Pregnancies__No. of Miscarriages_No. of Abortions__Number of living children_____
PMS__, Cramps with Mensus,__

FOR MEN ONLY:

Have you had prostate problems?_____infections?_____enlargement?_____
Have you had any of the following symptoms?:Frequent Urination_____How many times you awaken at night to urinate?____Do you have any decrease in flow of urination?___or dribbling?

HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS? IF SO WHEN?

WEIGHT LOSS_____
WEIGHTGAIN _____
FEVERS_____
CHILLS_____
BLURRED VISION_____
CIRCLS ARND EYES____
WEAR GLASSES_____
EYE INFECTIONS_____
DRY EYES_____
EAR ACHES_____
HEARING LOSS_____
RINGING IN EARS_____
EXCESS EAR WAX_____
SORE THROATS_____
SWOLLEN GLANDS____
LUMPS IN NECK_____
THYROID DESEASE____
COUGH_____
SPUTUM_____
WHEEZING_____
ASTHMA_____
HEART MUMUR_____
PNEUMONIA_____
BRONCHITIS_____
EMPHYSEMA_____
DIFFIC.BREATHING____
CHEST PAIN_____
HEART DISEASE_____
HEART ATTACK_____
ANGINA_____
HEART PALPITATIONS__
ANKLE SWELLING_____
CANCER_____
AIDS_____
HIV POSITIVE_____
NERVOUSNESS_____

DEPRESSION_____
HEADACHES_____
MIGRAINES_____
CHEST PAIN_____
DIZZINESS_____
HAIR LOSS_____
MOUTH ULCERS_____
ORAL HERPES_____
BLEEDING GUMS_____
ROOT CANALS_____
DRY MOUTH_____
TONSILITIS_____
BLOODY NOSE_____
NAUSEA_____
VOMITING_____
INTESTINAL GAS_____
PEPTIC ULCERS_____
DIARRHEA_____
CONSTIPATION_____
INTEST.PARASITES____
HEMORRHOIDS_____
HERNIA_____
BLACK STOOLS_____
GALLBLADDER DIS.____
BOWEL IRREGUL._____
INCONTINENCE_____
MENSTRUAL DYSFUN.__
HEPATITIS TYPE?_____
COLITIS_____
DIVERTICULITIS_____
HEARTBURN_____
FOOD ALLERGIES_____
APPETITE CHANGES___
DIABETES_____
HYPOGLYCEMIA_____
PROSTATE DISEASE___

KIDNEY DISEASE_____
KIDNEY INFECTIONS___
KIDNEY STONES_____
FREQ.URINATION_____
BLADDER INFECTIONS_
ARTHRITIS_____
JOINT PAINS_____
RHEUMATIC FEVER____
MUSCLE CRAMPS_____
BACK PAIN_____
DISC DISEASE_____
CHRONIC RASHES____
GOUT_____
PHLEBITIS_____
INSOMNIA_____
ANXIETY_____
MEMORY LOSS_____
PARALYSIS_____
MUMPS_____
MEASLES_____
RUBELLA_____
POLIO_____
FATIGUE_____
ANEMIA_____
BLOOD DISEASE_____
TUBERCULOSIS_____
MALASIA_____
EPSTEIN BARR_____
CMV_____
DIPHTHERIA_____
TETANUS_____
YEAST INFECTIONS____
CHICKEN POX_____
MENINGITIS_____
ENVIRONMENTAL ILLN._
OTHER_____

_____ SIGNATURE

_____ DATE