Confidential Health Information Questionnaire

Medical History

☐ Anemia	☐ Hypoglycemia	☐ Liver Disease
☐ Polio	☐ Dizziness	☐ Prolonged Bleeder
☐ Cancer	☐ Arthritis	☐ Venereal Disease
☐ Gout	☐ Hernia	☐ Nervous Disorder
☐ Diabetes	☐ Headaches	☐ Frequent Illness
☐ Phlebitis	☐ Emphysema	☐ Visual Disturbance
☐ Shortness of Breath	☐ Tuberculosis	☐ Circulation Problems
☐ Thyroid Problems	☐ High Blood Pressure	☐ Congestive Heart Failure
☐ Heart Attack (MI)	☐ Angina	☐ Other_____

List all hospitalizations for any medical illness or surgery. Please indicate reason and date:_____
_____

List all medical tests you have had within the past few years_____
_____

Are you currently or have you ever been treated for a heart or lung condition? ☐Yes ☐ No If yes, please explain(dates)_____

Do you have diabetes? ☐ Yes ☐ No ☐Don't know Family history of: ☐Yes ☐No ☐ Don't know
If yes, controlled by: ☐ Diet ☐ Drugs ☐ Uncontrolled
Have you had a blood cholesterol test in the past 1-2 years? ☐Yes ☐No If yes, results elevated? ☐ Not elevated? ☐

Current Medical Status

What is the nature of your visit?_____
_____

Are you pregnant? ☐ Yes ☐No How many months?_____

Have you recovered from COVID-19?_____ If so, when were you sick?_____

Please list any medications you are taking:_____
_____

Please list any medications you are allergic to:_____
_____

Have you changed weight in the past year? ☐Gained ☐Lost Number of pounds_____

Do you think you are overweight? ☐Yes ☐ No Are you on a diet? ☐Yes ☐ No Describe diet_____
_____

Do you have difficulty sleeping at night? ☐Yes ☐ No Time to bed_____ Time awake_____ # of hours of sleep_____

Briefly describe your physical level, include job description, and leisure activities_____
_____

Do you have adverse reactions to heat or cold? ☐ Yes ☐ No Cardiac Pacemaker? ☐Yes ☐No

Metal implants (plates, screws, IUD)? ☐Yes ☐No Explain_____

Do you have any skin areas which are sensitive or lack sensation? ☐Yes ☐No Where?_____

Have you had a recent infection or dental surgery? ☐Yes ☐No When_____ Where?_____

Name (last, first, initial)_____Date_____

Birthdate_____ Age_____ Sex ☐ M ☐F Height_____ Weight_____

Date_____ Patient Signature_____