

Medical Questionnaire

>>> You may type directly in the spaces provided <<<

| | | | | | | |
|--|----------------|-----------|------------|--------------------------------------|--------------------------|------------------------------------|
| Name: | | | | Sex: | Age: | DOB: |
| Weight: | Height: | HR | BP: | Physician Name & Phone #: | | |
| Have you ever been told you have: | | | | Y N | | |
| ◆ Cancer | | | | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any history of: |
| ◆ High blood pressure | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Diabetes | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Heart Disease | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Angina/chest pain | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Stoke | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Arthritis | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Osteopenia or osteoporosis | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you had or do you experience: Please describe in comments section → → → → | | | | | | Comments: |
| ◆ Nausea/vomiting | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Fever/chills/sweats | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Unexplained weight change | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Numbness or tingling | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Muscular weakness | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Fainting spells | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Dizziness | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Night pain | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Bowel or bladder changes | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Headaches | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Back pain | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Neck pain | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Shoulder pain | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Knee pain | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Foot pain | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ◆ Surgery | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you had any recent illness, to include upper respiratory infections (flu) or urinary tract infections (UTI)? Yes No Explain: | | | | | | |
| Do you smoke? Yes No If yes, how many packs per day? How long have you smoked? | | | | | | |
| Please list prescription medications you are currently taking here: | | | | | | |
| How often do you feel stress is a significant factor in your life? Never Seldom Occasionally Regularly Always | | | | | | |
| Date of last complete physical examination. Month Year Findings? | | | | | | |