Health Questionnaire

Please indicate for each of the question below, your experience by use of one of the following codes.

Codes: **1 for never had**; **2 for previously had**; **3 for presently have**.

MUSCULO- SKELETAL SYSTEM
CODE

____ Neck Problems
____ Arm Problems
____ Pain between shoulders
____ Low back problems
____ Leg Problems
____ Swollen joints
____ Painful joints
____ Stiff joints
____ Sore muscles
____ Weak muscles
____ Walking problems
____ Ruptures of tendons
____ Broken bones

GENITO- URINARY SYSTEM
CODE

____ Bladder trouble
____ Excessive urine
____ Scanty urine
____ Painful urination
____ Discolored urine

FEMALE
CODE

____ Vaginal Discharge
____ Vaginal bleeding
____ Vaginal pain
____ Breast pain
____ Lumps on breast

GASTRO-INTESTINAL SYSTEM
CODE

____ Poor appetite
____ Excessive hunger
____ Excessive thirst
____ Difficulty chewing
____ Difficulty swallowing
____ Nausea
____ Vomiting food
____ Vomiting blood
____ Abdominal pain
____ Diarrhea
____ Constipation
____ Black stool
____ Bloody stool
____ Hemorrhoids
____ Liver trouble
____ Gall bladder problems
____ Weight gain/loss

NERVOUS SYSTEM
CODE

____ Numbness
____ Paralysis
____ Dizziness
____ Fainting
____ Headaches
____ Muscle jerking
____ Convulsions
____ Forgetfulness
____ Confusion
____ Depression

CARDIO-VASCULAR- RESPIRATORY
CODE

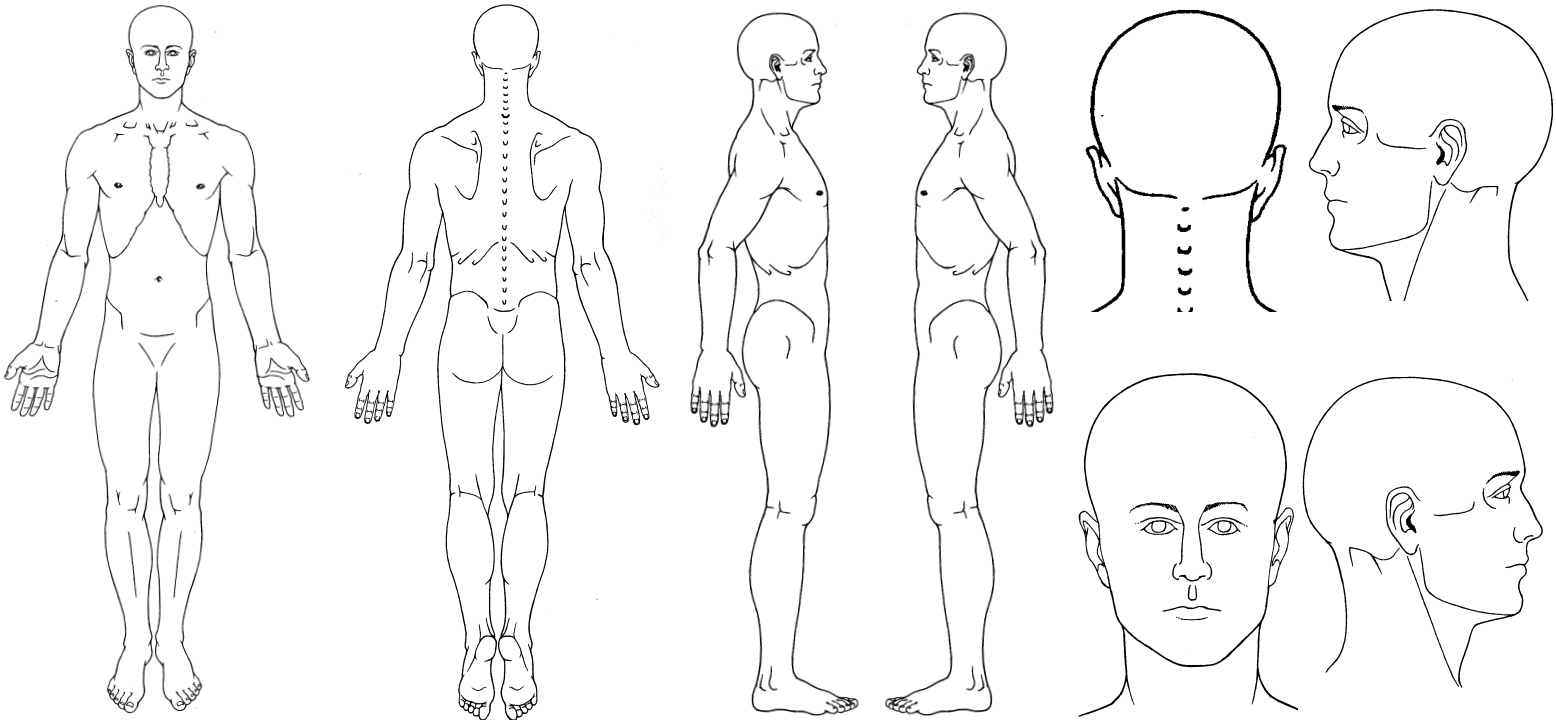
____ Chest pain
____ Heart pain
____ Rapid heart beat
____ Blood pressure high/low
____ Heart problems
____ Difficult breathing
____ Persistent cough
____ Coughing up phlegm
____ Coughing up blood
____ Lung problems
____ Varicose veins

EYE, EAR, NOSE AND THROAT
CODE

____ Eye strain
____ Eye inflammation
____ Vision problems
____ Ear pain
____ Ear noises
____ Hearing loss
____ Ear discharge
____ Nose pain
____ Nose Bleeding
____ Nose Discharge
____ Difficult breathing through nose
____ Sore gums
____ Dental problems
____ Sore mouth
____ Sore throat
____ Hoarseness
____ Difficult speech

Please indicate the location and sensation of your body pain using the following symbols:

^ ^ ^ ^ ^ ^ Numbness
o o o o o o o Pins and Needles
x x x x x x Burning
*** * * * * *** Aching/Dull
/ / / / / / Stabbing/Sharp
EEEEE Electrical



I understand that the doctor and the clinic staff have access to my health records for providing care. I am also assured that any information I provide is kept confidential. Therefore, I authorize the use of the above information as described.

Signature: _____ Date:_____

Your referrals are most welcomed.