

HEALTH QUESTIONNAIRE – Dr. Kate Klemer

Name _____ Date _____ Age _____ Ht _____ Wt _____

Family Medical History

- Allergies (Specify) Arteriosclerosis Cancer (Specify) Diabetes Seizures
Asthma Heart Disease Stroke
Alcoholism High Blood Pressure Mental Illness

Your Past Medical History

(Check any of the following conditions you currently have/ had in the past, or you feel are a significant part of your medical history.)

- Aids/HIV Diabetes Hernia Mumps Tuberculosis
Alcoholism Eating Disorder Herniated Disc Osteoporosis Typhoid Fever
Allergies Emotional Trauma High Blood Pressure Pacemaker Ulcers
Appendicitis Emphysema Kidney Disease Pleurisy Venereal Disease
Arteriosclerosis Epilepsy Knocked Unconscious Pneumonia Whooping Cough
Arthritis Fracture Measles Polio Other (Specify)
Asthma Glaucoma Mental Illness Rheumatic Fever
Birth Trauma Goiter Migraines Scarlet Fever
Cancer Gout Miscarriage Seizures
Caesarian Heart Disease Mono Stroke
Chicken Pox Hepatitis Multiple Sclerosis Thyroid Disorder

Your Diet

- Appetite: Low High Coffee Soft Drinks Artificial Sweetener Sugar Salty Food Thirst for water: # glasses/day

Average Daily Menu:

Table with 6 columns: Morning, Snack, Noon, Snack, Evening, Snack. Each column has three blank lines for input.

Pharmaceuticals taken in last 2 months: _____

Vitamins/Supplements taken in last 2 months: _____

Blood Type: O A AB B Other _____

Orthotics: Heel Lifts Arch Supports Sole Lifts Other _____

Your Lifestyle

- Alcohol Marijuana Stress Regular Exercise (Type and Frequency)
Tobacco Drugs Occupational Hazards

Spiritual Practice _____ Fun/Hobby _____

Mattress / Futon How much sleep/night? _____ How much sleep do you like to get? _____

General Symptoms

- Poor Appetite Poor sleep Bodily heaviness Chills Bleed/bruise
Heavy Appetite Heavy sleep Cold hands or feet Night sweats Peculiar taste:
Strongly like cold drinks Dream disturbed sleep Poor circulation Sweat easily
Strongly like hot drinks Fatigue Shortness of breath Muscle cramps
Recent weight loss/gain Lack of strength Fever Vertigo or dizziness

Head, Eyes, Ears, Nose, Throat

- Glasses
- Eye Strain
- Eye Pain
- Red Eyes
- Itchy Eyes)
- Spots in Eyes
- Poor Vision
- Blurred Vision
- Night Blindness
- Glaucoma
- Cataracts
- Teeth Problems
- Grinding Teeth
- TMJ
- Facial Pain
- Gum Problems
- Sores on Mouth/Lips
- Dry Mouth
- Excessive Saliva
- Sinus Problems
- Excessive Phlegm
- Color of phlegm:**

- Recurrent Sore Throat
- Swollen Glands
- Lumps in Throat
- Enlarged Thyroid
- Nose Bleeds
- Ringing in Ears
- Poor Hearing
- Earaches
- Headaches
- Migraines
- Concussions
- Other Head/Neck

- _____
- _____

Respiratory

- Difficulty breathing when lying down
- Shortness of breath
- Tight chest
- Asthma/wheezing
- Cough
Wet / Dry?
Thick / thin?
- Color of phlegm:**

- Coughing Blood
- Pneumonia

Cardiovascular

- High blood pressure
- Blood clots
- Low blood pressure
- Fainting
- Chest Pain
- Difficulty breathing
- Tachycardia
- Heart palpitations
- Phlebitis
- Irregular heartbeat

Musculoskeletal

- Neck/shoulder pain
- Muscle pain
- Upper back pain
- Low back pain
- Joint Pain
- Rib Pain
- Limited range of motion
- Limited use of: _____

Skin and Hair

- Rashes
- Hives
- Ulcerations
- Eczema
- Psoriasis
- Acne
- Dandruff
- Itching
- Change in texture
- Fungal infections
- Hair loss
- Other

Neuropsychological

- Seizures
- Numbness
- Tics
- Poor memory
- Depression
- Anxiety
- Irritability
- Easily stressed
- Abuse survivor
- Considered/Attempted Suicide
- Seeing a therapist
- Other _____

Genito-urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Venereal Disease
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stone
- Impotence
- PreEjaculation
- NocEmission

Gynecology

- Age menses began _____
- Length of cycle _____
- Duration of flow _____
- Date of last PAP _____
- Irregular Periods
- Painful periods
- Painful periods
- Date last period began _____
- PMS
- Vaginal discharge
color: _____
- Vaginal odor
- Vaginal sores
- Clots
- Breast lumps
- # of live births _____
- Premature births _____
- Age at menopause _____
- # of pregnancies _____

Surgery (with approximate date):

- _____
- _____

Major Trauma (list any falls, car accidents or other major trauma with approximate date of incident):

- _____
- _____

Date of Last: Physical _____ Blood Test _____ Chest Xray _____ Spine Xray _____
 CT Scan _____ Urine Test _____ MRI _____ Bone Density _____

The information I have given is accurate and I have read the Health Questionnaire entirely. _____ Date _____

 Patient Signature