HEALTH QUESTIONNAIRE

Name: _____
Age: _____

Do you have any of the following medical conditions? (circle all that apply)

Immune system compromise
Osteoporosis
Rheumatic Disease
Open wounds
History of seizures
Diabetes mellitus
Cancer or history of cancer
Surgeries
History of pain in joints or muscles (please specify)
Weakness/Sensation changes (numbness/tingling)
High blood Pressure/Low blood pressure
Heart disease
Liver disease
Kidney disease
Incontinence
Respiratory disease

Please explain for conditions circled: _____
_____
_____

Answer the following statements by circling yes or no.
Have you had:

1. an unexplained weight loss of greater than 10 pounds in the past month? Yes/No
2. numbness in both hands and both feet at the same time? Yes/No
3. any changes in your bowel or bladder habits? Yes/No
4. incoordination with walking? Yes/No
5. any dizziness when you turn your head? Yes/No
6. blurring of your vision? Yes/No
7. slurring of your speech or difficulty swallowing? Yes/No
8. any episodes of fainting? Yes/No

Explain for yes answers: _____
_____
_____

M.D. Name:
M.D. phone #:
M.D. fax #:

_____ _____
Signature Date