



## MEDICAL HISTORY QUESTIONNAIRE

THE FOLLOWING INFORMATION IS REQUESTED TO DETERMINE YOUR CURRENT MEDICAL STATUS

DATE \_\_\_\_\_

1. NAME (LAST) \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ 2. SOCIAL SECURITY # \_\_\_\_\_

3. ADDRESS (NUMBER & STREET) \_\_\_\_\_ CITY/STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ 4. TELEPHONE # \_\_\_\_\_

5. SEX \_\_\_\_\_ 6. BIRTH DATE \_\_\_\_\_  
 MALE/FEMALE \_\_\_\_\_

7. NAME AND ADDRESS OF PERSONAL PHYSICIAN \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

8. ARE YOU:  
 \_\_\_\_\_ RT. HANDED  
 \_\_\_\_\_ LT. HANDED  
 \_\_\_\_\_ AMBIDEXTROUS

9. INJURIES: PLEASE CHECK ANY INJURIES YOU HAVE HAD AND EXPLAIN BELOW

_____ FRACTURES-BROKEN BONES	_____ DISLOCATIONS	_____ LOW BACK PAIN	_____ OTHER INJURY (EXPLAIN)
_____ SEVERE BURNS	_____ LOSS OF CONSCIOUSNESS	_____ BACK INJURY	
_____ SEVERE CUTS	_____ LOSS OF ARM, FINGER, TOE	_____ NONE	

10. PERSONAL HISTORY: DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING? (CHECK EACH BOX AND EXPLAIN YES ANSWERS BELOW)

	YES	NO		YES	NO		YES	NO
ASTHMA	___	___	GALL BLADDER DISORDER	___	___	PALPITATION POUNDING HEART	___	___
ANEMIA	___	___	GOITER/THYROID PROBLEMS	___	___	POSITIVE TB SKIN TEST	___	___
CANCER, CYST OR TUMOR	___	___	HAYFEVER/ALLERGIES	___	___	REACTION FROM MEDICINES	___	___
CHEST PAIN, SHORTNESS OF BREATH	___	___	HEADACHES, FREQUENT OR SEVERE	___	___	RECENT GAIN/LOSS OF WEIGHT	___	___
CHICKENPOX	___	___	HEART TROUBLE	___	___	RHEUMATIC FEVER	___	___
CHRONIC COUGH OR FREQUENT COLDS	___	___	HEMORRHOIDS/RECTAL PROBLEMS	___	___	RHEUMATISM OR ARTHRITIS	___	___
CONVULSIONS OR SEIZURES	___	___	HERNIA	___	___	SCARLET FEVER	___	___
DEPRESSION/EXCESSIVE WORRY	___	___	HIP, LEG, OR FOOT INJURY	___	___	SHOULDER/ARM/HAND INJURY	___	___
DERMATITIS	___	___	JAUNDICE OR HEPATITIS	___	___	SKIN RASH OR HIVES	___	___
DIABETES/SUGAR IN URINE	___	___	KIDNEY TROUBLE/BLOOD IN URINE	___	___	STOMACH TROUBLE, ULCERS	___	___
DIZZINESS	___	___	HIGH BLOOD PRESSURE	___	___	STROKE/PARALYSIS	___	___
DRUG OR ALCOHOL PROBLEMS	___	___	LIVER DISORDER	___	___	SWELLING OF ANKLES OR JOINTS	___	___
EAR/NOSE/THROAT DISORDER	___	___	LOCKED KNEE OR "TRICK JOINT"	___	___	SWOLLEN OR PAINFUL JOINTS	___	___
EYE DISORDER	___	___	LOSS OF APPETITE, CHRONIC	___	___	TUBERCULOSIS	___	___
FAINTING	___	___	LUNG DISEASE	___	___	VOMITING/COUGHING/SPITTING UP BLOOD	___	___
FATIGUE, CHRONIC OR FREQUENT	___	___	MALARIA	___	___			
FOOT PROBLEMS	___	___	MASS/BULGE IN GROIN	___	___			
FREQUENT INGESTION/HEARTBURN	___	___	NERVOUS BREAKDOWN	___	___			
FREQUENT TROUBLE SLEEPING	___	___	NUMBNESS, WEAKNESS	___	___			
FREQUENT/PAINFUL URINATION	___	___	PAIN IN GROIN WHEN LIFTING	___	___			

EXPLANATIONS (9 OR 10): PLEASE INCLUDE DATES AND NAME OF ATTENDING PHYSICIAN

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11. FAMILY HISTORY: CHECK IF ANYONE IN YOUR FAMILY HAS OR HAD:

\_\_\_ TUBERCULOSIS      \_\_\_ EPILEPSY      \_\_\_ DIABETES      \_\_\_ HIGH BLOOD PRESSURE  
\_\_\_ MENTAL DISORDER      \_\_\_ CANCER      \_\_\_ HEART DISEASE      \_\_\_ OTHER \_\_\_\_\_

12. CHECK YES OR NO-IF YES, GIVE DETAILS IN BLANK AREA: YES      NO

HAD ANY SERIOUS ACCIDENT OR ILLNESS? \_\_\_\_\_ \_\_\_      \_\_\_

HAD ANY INFECTIOUS DISEASE WHICH INCLUDES  
HEPATITIS B OR HTLV III ANTIBODY POSITIVE REACTION? \_\_\_\_\_ \_\_\_      \_\_\_

BEEN A PATIENT IN A HOSPITAL? \_\_\_\_\_ \_\_\_      \_\_\_

HAD SURGERY RECOMMENDED OR PERFORMED?  
(DATE AND TYPE) \_\_\_\_\_ \_\_\_      \_\_\_

ARE YOU TAKING MEDICINES NOW? \_\_\_\_\_ \_\_\_      \_\_\_

HAVE YOU EVER LOST TIME FROM A WORK INJURY? \_\_\_\_\_ \_\_\_      \_\_\_

HAVE YOU EVER BEEN INFORMED OF ANY ABNORMAL  
FINDINGS FROM A PHYSICAL EXAMINATION? \_\_\_\_\_ \_\_\_      \_\_\_

DO YOU SMOKE? IF YES, QUANTITY PER DAY \_\_\_\_\_ \_\_\_      \_\_\_

DO YOU USE ALCOHOLIC BEVERAGES? IF YES,  
QUANTITY PER DAY \_\_\_\_\_ \_\_\_      \_\_\_

HAVE YOU LIVED, OR TRAVELED, OUTSIDE THE  
CONTINENTAL U.S.A.? \_\_\_\_\_ \_\_\_      \_\_\_

WHAT DO YOU CONSIDER TO BE THE STATE OF YOUR HEALTH?

\_\_\_\_\_  
\_\_\_\_\_

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE