Medical Health Questionnaire

Name_____ **DOB**_____ **Date**_____

Constitution
Cancer
Develop Disabilities
Fatigue
Other_____

ENT
Dry Mouth
Hearing Loss
Laryngitis
Sinusitis
Other_____

Neuro
Cerebral Palsy
Epilepsy
Migraine
Multiple Sclerosis
Stroke/Cva
Tumor
Other_____

Psychiatric
Anxiety Disorder
Attention Deficit
Bipolar Disorder
Depression
Other_____

Cardiovascular
Congestive Heart Failure
Heart Disease
High Blood Pressure
Stroke/Cva
Vascular Disease
Other_____

Respiratory
Asthma
Bronchitis
Chronic Obstruction
Emphysema
Sleep Apnea
Other_____

Gastrointestinal
Acid Reflux
Celiac Disease
Crohn's Disease
Colitis
Other_____

Genitourinary
Benign Prostate
Hypertrophy
Chlamydia
Herpes
Kidney Disease
Nursing
Pregnant
Prostate Disease/Cancer
Other_____

Musculoskeletal
Ankylosing Spondylitis
Arthritis
Fibromyalgia
Gout
Muscular Dystrophy
Osteoarthritis
Osteoporosis
Other_____

Integumentary
Eczema
Herpes Simplex/cold Sores
Herpes Zoster/Shingles
Psoriasis
Rosacea
Other_____

Hematologic/Lymphatic
Anemia
Diabetes Type 1
Diabetes Type 2
High Cholesterol
Large Volume Blood Loss
Ulcer
Other_____

Allergic/Immune
Drug Allergies
Environmental Allergies
Lupus
Rheumatoid Arthritis
Sjogrens Syndrome
Other_____

Medications and Dosage
_____
_____
_____
_____
_____
_____
_____

Please complete reverse side

	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER	UNKNOWN
CANCER (If yes please indicate type in comments below)							
TYPE 1 DIABETES							
TYPE 2 DIABETES							
HYPERTENSION							
HYPERTHYROIDISM							
HYPOTHYROIDISM							
CATARACT							
MACULAR DEGENERATION							
GLAUCOMA							

Family Health Comments:_____

Preferred Language: English Spanish French Other:_____

Race: Asian Black or African American White Pacific Islander / Hawaiian American Indian Alaska Native Unknown Other: _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino