Health History Questionnaire

Name: _____ Date of Evaluation: _____

MEDICAL HISTORY

Please place an X in any of the boxes below that applies to you or a family member, whether a current or past problem.

	You	Family	
□ irregular heart beat	____	_____	
□ angina	____	_____	
□ pacemaker	____	_____	
□ heart surgery	____	_____	
□ heart attacks	____	_____	
□ heart valve problems	____	_____	
□ high blood pressure	____	_____	
□ high cholesterol	____	_____	
□ asthma	____	_____	
□ emphysema	____	_____	
□ chronic bronchitis	____	_____	
□ hay fever	____	_____	
□ arthritis	____	_____	
□ osteoporosis	____	_____	
□ bleeding disorders	____	_____	
□ kidney disorder	____	_____	
□ seizures	____	_____	
□ cancer	____	_____	
□ diabetes	____	_____	
□ gastrointestinal disorder	____	_____	specify_____
□ muscle or nerve diseases	____	_____	specify_____

Have you ever had any types of surgery? __ Y __ N if so please explain _____

_____

Have you ever become weak or ill when exposed to high temperatures? __ Y __ N

Do you smoke? __ Y __ N Packs per day? _____

Have you ever received physical therapy? __ Y __ N

What ailment did you get treated for? _____

Patient signature _____