Medical Questionnaire

Name: ______________________ Sex: ______________________

Phones: ______________________ Weight/Height: ______________________

Address: ______________________ Occupation: ______________________

Birth Date: ______________________ Refference: ______________________

Chief Complaint: ____

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Family Health:

- ☐ Alcoholism
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Allergies
- ☐ Epilepsy
- ☐ Stroke
- ☐ Cancer
- ☐ Heart disease
- ☐ Other

Details: ____

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Patient Medical History:

- ☐ Accidents, injuries, traumas
- ☐ Diabetes
- ☐ Hyperactive thyroid
- ☐ Low blood pressure
- ☐ Surgeries
- ☐ Allergies
- ☐ Epilepsy
- ☐ Hypoactive thyroid
- ☐ Medications in use
- ☐ Other
- ☐ Cancer
- ☐ Hypertension
- ☐ Joint diseases
- ☐ Scars

Details: ____

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General Info:

- ☐ A need to sleep a lot
- ☐ Disturbing dreams/nightmares
- ☐ Fainting
- ☐ Insomnia
- ☐ Light sleep
- ☐ Preference for warm drinks
- ☐ Shivers, chills
- ☐ Cold abdomen or back
- ☐ Excessive perspiration
- ☐ Fatigue
- ☐ Lack of perspiration
- ☐ Perspires easily
- ☐ Restless sleep
- ☐ Other
- ☐ Cold limbs
- ☐ Extreme thirst
- ☐ Hormonal disorders
- ☐ Lack of thirst
- ☐ Preference for cold drinks
- ☐ Sensitivity to weather changes

Details: ____

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Medical Questionnaire

Hair / Skin:

- ☐ Acne/pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Oily skin
- ☐ Other
- ☐ Allergies
- ☐ Dry scalp
- ☐ Hematomas
- ☐ Psoriasis
- ☐ Brittle hair/nails
- ☐ Eczema
- ☐ Itchiness
- ☐ Skin rashes

Details: ______________________________

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Head / Neck:

- ☐ Bad breath
- ☐ Blurred or weak vision
- ☐ Dry eyes
- ☐ Ear aches
- ☐ Glaucoma
- ☐ Hoarseness
- ☐ Night blindness
- ☐ Red eyes
- ☐ Stuffiness in the head
- ☐ Teeth grinding
- ☐ Bleeding from gums
- ☐ Cataract
- ☐ Dry mouth
- ☐ Floaters in the vision
- ☐ Headaches, migraines
- ☐ Itchy eyes
- ☐ Otitis/ear infection
- ☐ Sinusitis
- ☐ Stuffy nose
- ☐ Tongue/ mouth ulcers
- ☐ Bleeding from nose
- ☐ Dizziness
- ☐ Dry throat
- ☐ Gingivitis
- ☐ Hearing disorders
- ☐ Low humming in ears/tinnitus
- ☐ Pressure in head or behind the eyes
- ☐ Sore throat
- ☐ Swollen glands in the neck
- ☐ Other

Details: ______________________________

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Heart / Blood Vessels:

- ☐ Arrhytmia
- ☐ Edemas
- ☐ Low blood pressure
- ☐ Varicose veins
- ☐ Catheterization
- ☐ Heart surgeries
- ☐ Palpitations
- ☐ Other
- ☐ Chest pains
- ☐ Hypertention
- ☐ Tromboza/blood coagulation

Details: ______________________________

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Lungs / Breath:

- ☐ Asthma
- ☐ Chronic runny nose
- ☐ Dry coughing
- ☐ Heavy breathing
- ☐ Sensitivity to cold
- ☐ Sensitivity to humidity
- ☐ Sneezing
- ☐ Other
- ☐ Bronchitis
- ☐ Cough with white phlegm
- ☐ Dry mucus membranes
- ☐ Phlegm/sputum
- ☐ Sensitivity to dryness
- ☐ Sensitivity to wind
- ☐ Snoring
- ☐ Chronic cough
- ☐ Cough with yellow phlegm
- ☐ Frequent colds
- ☐ Pneumonia
- ☐ Sensitivity to heat
- ☐ Shortness of breath
- ☐ Wheezing

Details: ______________________________

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Medical Questionnaire

Digestion System:

- ☐ Appetite deficiency
- ☐ Constipation
- ☐ Craving for sour foods
- ☐ Excessive appetite
- ☐ Heartburn
- ☐ Prolapse of stomach/intestine
- ☐ Weird tastes
- ☐ Belching/hiccups
- ☐ Craving for bitter foods
- ☐ Craving for sweet foods
- ☐ Flatulence,bloating
- ☐ Hemorrhoids/piles
- ☐ Stomachaches
- ☐ Other
- ☐ Bloody excretion from anus
- ☐ Craving for salty foods
- ☐ Diarrhea
- ☐ Frequent bowel movements per day
- ☐ Nausea
- ☐ Vomiting

Details: ______________________________

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Urinary System:

- ☐ A burning sensation when urinating
- ☐ Dribbling after urination
- ☐ Light colored urine
- ☐ Scanty urination
- ☐ Other
- ☐ Dark colored urine
- ☐ Excessive urination
- ☐ Nocturnal urination
- ☐ Urinary frequency
- ☐ Difficulty in urination
- ☐ Incontinence
- ☐ Prolapse of urinary bladder
- ☐ Urinary urgency

Details: ______________________________

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Skeletal / Muscles:

- ☐ Heaviness of limbs
- ☐ Lower back pains
- ☐ Numbness of limbs
- ☐ Tense neck
- ☐ Upper back pains
- ☐ Weakness in muscles
- ☐ Other
- ☐ Joint diseases
- ☐ Middle back pains
- ☐ Osteoporosis
- ☐ Tense shoulders
- ☐ Weakness in back
- ☐ Weakness in neck
- ☐ Joint pains
- ☐ Muscle cramps, pains
- ☐ Spinal column disorders
- ☐ Tingling of limbs
- ☐ Weakness in limbs
- ☐ Weakness in shoulders

Details: ______________________________

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Neuro Psychology:

- ☐ Anger
- ☐ Depression
- ☐ Excessive worrying/easily worried
- ☐ Mood swings
- ☐ Sadness
- ☐ Suicidal thoughts
- ☐ Other
- ☐ Anxiety
- ☐ Difficulty in focusing, concentrating
- ☐ Fears
- ☐ Nervousness
- ☐ Sighs
- ☐ Was treated with psychiatric medicines
- ☐ Apathy
- ☐ Easily irritated
- ☐ Insecurity
- ☐ Oversensitivity
- ☐ Stress

Details: ______________________________

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Medical Questionnaire

Woman:

- ☐ Abridged menstruation
- ☐ Blood clots during menstruation
- ☐ Contraceptives
- ☐ Diminished libido
- ☐ Hot flashes
- ☐ Lessened amount of blood during menstruation
- ☐ Menopause
- ☐ Number of days during menstruation
- ☐ Painful menstruation
- ☐ Prolapse of uterus
- ☐ Vaginal discharges
- ☐ Bleeding in between the menstruations
- ☐ Brown blood
- ☐ Dark blood
- ☐ Excessive blood during menstruation
- ☐ Intermission of menstruation
- ☐ Mood swings before menstruation
- ☐ Number of miscarriages
- ☐ Post menstrual pains
- ☐ Prolapse of vagina
- ☐ Vaginal infections
- ☐ Burning sensation of genital organs
- ☐ Date of last gynecologist checkup
- ☐ Extended menstruation
- ☐ Irregular menstruation
- ☐ Light/pale red blood
- ☐ Number of babies
- ☐ Number of pregnancies
- ☐ Premenstrual pains/soreness (pms)
- ☐ Sexually-related disorders
- ☐ Other

Details: ____

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Man:

- ☐ Diminished libido
- ☐ Impotence
- ☐ Nocturnal urination
- ☐ Sexually related disorders
- ☐ Genital discharge
- ☐ Increased libido
- ☐ Premature ejaculation
- ☐ Other
- ☐ Genital pains
- ☐ Nocturnal emission
- ☐ Prostate disorders

Details: ____

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Nutrition / Activity:

- ☐ List daily diet
- ☐ Dinner
- ☐ Other
- ☐ Breakfast
- ☐ In-Between meals
- ☐ Lunch
- ☐ List daily physical activity/activities

Details: ____

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Habits:

- ☐ Addictive drugs
- ☐ Excessive amount of salt
- ☐ Soft drinks-number of glasses a day
- ☐ Alcohol
- ☐ Excessive amount of sugar
- ☐ Other
- ☐ Coffee-number of cups a day
- ☐ Smoking-number of cigarettes a day

Details: ____

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