FAIRVIEW

TRUSTED FOR GENERATIONS

Health History Questionnaire

Name: ______________________________ Date: ______________________

Past Medical History: Please check all that apply.

Bone Disease □ Osteoporosis/Osteopenia □ Osteoarthritis □ Metal implants or prosthetic □ Heart disease □ Heart Attack □ Angina Pectoris□ Anemia □ Atrial fibrillation □ Orthostatic blood pressure/Low blood pressure □ Dizziness □ Hypertension □ High Cholesterol □ Pacemaker □ Vertigo □ Seizures □ Tuberculosis □ Kidney disease □ Hepatitis □ Diabetes Type I □ Diabetes Type II □ Hyperthyroidism □ Hypothyroidism □ New onset of night sweats □ Depression □ Mental illness □ Alcohol Abuse/Drug dependency □ Migraines □ HIV / AIDS □ Autoimmune disorder □ Respiratory disorder □ Asthma □ Difficulty swallowing □ Change in bowel and bladder □ Stroke □ Parkinson's disease □ Peripheral neuropathy □

Other neurological disorder □ If yes, please specify:

____

Cancer □ If yes, please specify:

____

Other □

____

Health Maintenance: Date of last physical: ____

Do you wear contacts or glasses: __________________ If so, which? ____________________

Past Surgical History: Have you ever had surgery? _______________________ If yes, please list:

Type: ____ Year: _________________

Type: ____ Year: _________________

Type: ____ Year: _________________

Type: ____ Year: _________________

Type: ____ Year: _________________

Allergies: Are you allergic to medications, latex, or any food? __________________ If yes, please list: ____

Do you have any additional allergies? ____________________ If yes, please list:

____

Medication: List all medication and supplements you take:

Medication ______________________________ Dosage ______________ Frequency ____________

Medication ______________________________ Dosage ______________ Frequency ____________

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Medication ______________________________ Dosage ______________ Frequency ____________

What is your primary reason for seeking treatment today?

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How would you describe your daily activity level? Please circle one of the following:

Sedentary Light Physical Moderate Physical Heavy physical

Do you have a history of falls? ______________ If yes, how many falls have occurred in the last year?____

Have you had any recent imaging or diagnostic testing done recently? ________________ If yes, please list.

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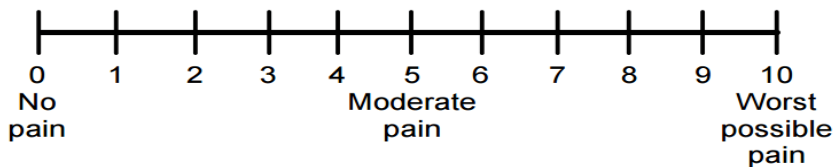
Do you have pain? _____________ If so, where? ____

Please rate your pain on the scale below:



Patient/Responsible Party Signature Date

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