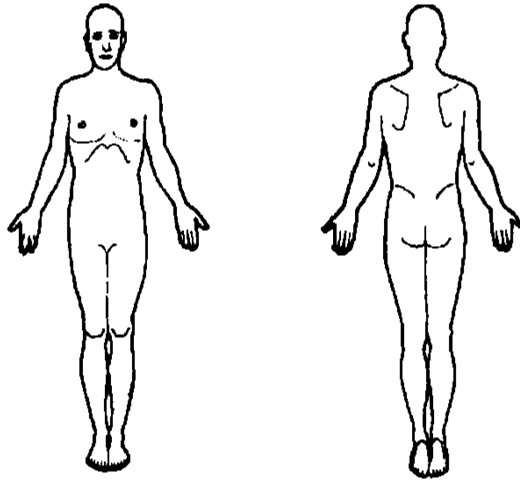
Health History Questionnaire

Patient name ____ **Date** ________________

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure Yes No
2. Hardening of the arteries (arteriosclerosis) Yes No
3. Diabetes Yes No
4. Tuberculosis Yes No
5. Cancer Yes No
   Where? ____
6. Heart or blood diseases Yes No
7. Bone spurs on the neck bones (cervical sprain) Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain) Yes No
9. Have you or any of your relatives ever suffered a stroke? Yes No
10. Were you ever a smoker? Yes No
    From ____________________ to __________________
11. Do you take medication on a regular basis? Yes No
12. Visual disturbances (blurring, loss, double vision) Yes No
13. Hearing disturbances (loss, ringing, other noise) Yes No
14. Slurred speech or other speech problems Yes No
15. Difficulty swallowing Yes No
16. Dizziness Yes No
17. Loss of consciousness, even momentary blackouts Yes No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body? Yes No
19. Sudden collapse without loss of consciousness Yes No

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

| 0 1 2 3 4 5 6 7 8 9 10 |

No pain Extreme pain