

**Patient Vital Intake [HQ]
Health Questionnaire**

Name _____ Home Phone _____ Work _____

Birthdate: ____/____/____ Age: _____ Height _____ Weight _____ Cell Phone _____

Complaints: How long/Onset _____ Treatment/Palliative action (what makes it better) _____

List ALL Surgeries / Trauma / Medications / Allergies (give dates, age or year as best you can remember)

Family Medical History:

Obesity Stroke Seizures Other Dz/Cancer _____
 Diabetes Heart DZ High Blood Pressure

Your Habits:

Cigarettes Marijuana (occasionally often)
 Street Drugs Please explain _____
 Coffee Cola/Carbonated Beverages }
 Tea } cups, glasses, cans, etc /day _____
 Bitter Chocolat Sweet/milk Chocolat
 Alcohol drinks /week _____
 Sugar Artificial Sweetener
 Salt Explain any cravings _____

NOTES

General

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Heavy sleep |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tremors | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold back | <input type="checkbox"/> Cold abdomen |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Sudden energy drop at _____ (time) | | <input type="checkbox"/> Peculiar tastes/smells _____ | |
| <input type="checkbox"/> Strong thirst (cold/hot drinks) _____ | | <input type="checkbox"/> Bleed or bruise easily (where) _____ | |

SKIN AND HAIR

- | | | | |
|--|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair |
| <input type="checkbox"/> Change in hair/skin texture | <input type="checkbox"/> Purpura | <input type="checkbox"/> Other hair or skin problem _____ | |

HEAD, EYES, EARS, NOSE, AND THROAT

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Mucus | <input type="checkbox"/> Dry throat | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Copious saliva |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Gum problems | <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Recurrent sore throats _____/mouth | |
| <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Headaches (where and when) _____ | | |
| <input type="checkbox"/> Other head or neck problems _____ | | | |

Name _____

Date _____

CARDIOVASCULAR

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swelling in hands/feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Other |

RESPIRATORY

- | | | | |
|--|--|---------------------------------|--------------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Difficulty in breathing when lying down | | <input type="checkbox"/> Tight chest |
| <input type="checkbox"/> Production of phlegm _____ what color _____ | | | |

GASTROINTESTINAL

- | | | | |
|---|---|--|--------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | Bowel Movement: |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black stool | _____ Frequency |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids | _____ Color |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Sensitive abdomen | _____ Odor |
| <input type="checkbox"/> Pain or cramps | <input type="checkbox"/> Laxative use: _____/week; type _____ | | _____ Texture/form |

GENITO-URINARY

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urgency to urinate |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Impotency |
| <input type="checkbox"/> Wake up to urinate | How often _____/night; time: _____ | | <input type="checkbox"/> Other G/U problems |

PREGNANCY AND GYNECOLOGY

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Number pregnancies | <input type="checkbox"/> Number births | <input type="checkbox"/> Premature births | <input type="checkbox"/> Miscarriages |
| <input type="checkbox"/> Age at first menses | <input type="checkbox"/> Period (days) | <input type="checkbox"/> Duration | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Flow (describe) | <input type="checkbox"/> Clots | Last PAP _____ | Last menses _____ |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Breast lumps | Menopause _____ |
| <input type="checkbox"/> Birth control type and duration _____ | | <input type="checkbox"/> Changes in body/psyche prior to menstruation | |

MUSCULOSKELETAL

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pains | <input type="checkbox"/> Back pain (where) _____ | <input type="checkbox"/> Joint pains (where) _____ |
| <input type="checkbox"/> Other joint or bone problems? | | | |

NEUROPSYCHOLOGICAL

- | | | | |
|--|--|--------------------------------------|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bad temper | <input type="checkbox"/> Easily stressed |
| <input type="checkbox"/> Treated for emotional problems | | | <input type="checkbox"/> Considered/attempted suicide |
| <input type="checkbox"/> Other neurological or psychological problems? | | | |

Signature _____

Dated _____