ADVANCED HEALTH SERVICES, LLC
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MEDICAL HISTORY AND HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____
DOB: _____ AGE: _____ GENDER: F _____ M _____
ADDRESS: _____
_____
TELEPHONE: (_____) _____ FAX: (_____) _____
EMAIL: _____
OCCUPATION _____ REFERRED BY: _____
CHIEF COMPLAINT (LIST THE CURRENT SYMPTOMS AND BEGINNING DATE) _____
_____
_____
_____
_____
LIST OF MEDICATIONS _____
_____
_____

FAMILY HISTORY

(Including all blood relatives)

			RELATIONSHIP				RELATIONSHIP
CANCER	YES	NO	_____	STROKE	YES	NO	_____
DIABETES	YES	NO	_____	HEART PROB.	YES	NO	_____
HYPERTENSION	YES	NO	_____	EPILEPSY	YES	NO	_____
DRUG PROB.	YES	NO	_____	ALCOHOL PROB.	YES	NO	_____
MENTAL ILLNESS	YES	NO	_____	DEPRESSION	YES	NO	_____
MIGRAINE HEADACHE	YES	NO	_____	ULCER	YES	NO	_____
THYROID PROB.	YES	NO	_____	OBESITY	YES	NO	_____
KIDNEY PROB.	YES	NO	_____	ASTHMA	YES	NO	_____

OTHER HEALTH PROBLEMS _____

MEDICAL HISTORY

LIST ALL SERIOUS ILLNESSES _____
_____
_____
LIST SURGICAL PROCEDURES _____
_____
_____
_____
LIST SERIOUS ACCIDENTS, HARD FALLS, OR BROKEN BONES _____
_____
_____

GENERAL

MEASLES _____	YES	NO
MUMPS _____	YES	NO
CHICKENPOX _____	YES	NO
ALLERGY _____	YES	NO
TIREDNESS _____	YES	NO
PERSISTENT FEVER _____	YES	NO
CHILLS _____	YES	NO
DIZZINES _____	YES	NO
FAINTING _____	YES	NO
FATIGUE _____	YES	NO
HEADACHES _____	YES	NO
NERVOUSNESS _____	YES	NO
NUMBNESS _____	YES	NO
NEURALGIA _____	YES	NO
SLEEPLESSNESS _____	YES	NO

DEPRESSION _____	YES	NO
POOR CONCENTRATION _____	YES	NO
MEMORY LOSS _____	YES	NO
RAPID LOSS OF WEIGHT _____	YES	NO
RAPID INCREASE IN WEIGHT _____	YES	NO
SWEATS _____	YES	NO
DETERIORATION OF EYE SIGHT _____	YES	NO
EYE PAIN _____	YES	NO
DETERIORATION OF HEARING _____	YES	NO
RINING IN THE EARS _____	YES	NO
EARACHE _____	YES	NO
GUM TROUBLE _____	YES	NO
DENTAL DECAY _____	YES	NO
CHANGE IN HAIR _____	YES	NO
CHANGE IN NAILS _____	YES	NO

GASTRO-INTESTINAL

BELCHING OR GAS _____ YES NO
COLITIS _____ YES NO
ULCER _____ YES NO
HEMORRHOIDS _____ YES NO
CONSTIPATION _____ YES NO
RECTAL BLEEDING _____ YES NO
DIARRHEA _____ YES NO
HEARTBURN _____ YES NO
EXCESSIVE HUNGER _____ YES NO
INCREASE IN THIRST _____ YES NO
GALL BLADDER STONES _____ YES NO
LIVER PROBLEM _____ YES NO
HEPATITIS _____ YES NO
INFECTIOUS MONO _____ YES NO
NAUSEA _____ YES NO
INTESTINAL WORMS _____ YES NO
STOMACH PAIN _____ YES NO
POOR APPETITE _____ YES NO
VOMITING _____ YES NO

RESPIRATORY

FREQUENT COLDS _____ YES NO
SORE THROAT _____ YES NO
SINUS INFECTION _____ YES NO
FREQUENT COLDS IN CHILDHOOD _____ YES NO
CHRONIC COUGH _____ YES NO
DIFFICULTY BREATHING _____ YES NO
BRONCHITIS _____ YES NO
ASTHMA _____ YES NO
WHEEZING _____ YES NO
TUBERCULOSIS _____ YES NO

CARDIO-VASCULAR

SHORTNESS OF BREATH _____ YES NO
RAPID BEATING HEART _____ YES NO
SLOW BEATING HEART _____ YES NO
MITRAL VALVE PROLAPSE _____ YES NO
SWELLING _____ YES NO
CLOGGED ARTERIES _____ YES NO
HIGH BLOOD PRESSURE _____ YES NO
LOW BLOOD PRESSURE _____ YES NO
STROKE _____ YES NO
HEARTATTACK _____ YES NO

MUSCULO-SKELITOL

BACKACHES _____ YES NO
STIFF NECK _____ YES NO
SWOLLEN JOINTS _____ YES NO
JOINT PAIN _____ YES NO
JOINT STIFFNESS _____ YES NO
PAINFUL COCCIX _____ YES NO
RHEUMATIC FEVER _____ YES NO
ARTHRITIS _____ YES NO
MUSCLE SPASMS _____ YES NO
LEG CRAMPS (WALKING OR NIGHT) _____ YES NO
HERNIA _____ YES NO
MUSCLE WEAKNESS _____ YES NO
POLIO _____ YES NO

GENITO-URINARY

FREQUENT URINATIONS (DAY) _____ YES NO
FREQUENT URINATIONS (NIGHT) _____ YES NO
INABILITY TO CONTROL URINE _____ YES NO
KIDNEY PROBLEM _____ YES NO
BLADDER INFECTIONS _____ YES NO
BLOOD IN URINE _____ YES NO
PAINFUL URINATION _____ YES NO
PROSTATE PROBLEM _____ YES NO
LACK OF SEX DRIVE _____ YES NO
VENERIAL INFECTION _____ YES NO

ENDOCRINE

MIGRAINE HEADACHES _____ YES NO
OVARIAN CYSTS _____ YES NO
UTERUS FIBROID _____ YES NO
THYROID GLAND PROBLEM _____ YES NO
PITUITARY GLAND PROBLEM _____ YES NO
ADRENAL GLAND PROBLEM _____ YES NO
PANCREAS PROBLEM _____ YES NO
HYGHPERGLUSIMIA _____ YES NO
HYPOGLUSIMIA _____ YES NO

MEN ONLY

DISCHARGE FROM PENIS _____ YES NO
PAIN IN TESTICLES _____ YES NO
LUMP IN TESTICLES _____ YES NO
IMPOTENCE _____ YES NO

WOMEN ONLY

AGE MENSTRUAL PERIOD BEGAN _____
DAY THAT IT LASTS/LASTED _____
NUMBER OF DAYS IN BETWEEN _____
HEAVY FLOW _____ YES NO
BLEED OR SPOT _____ YES NO
BETWEEN PERIODS
MENSTRAL PERIOD CRAMPS _____ YES NO
DIZZINESS WITH MENSTRUAL PERIOD _____ YES NO
ITCHING IN VEGINAL AREA _____ YES NO
PAIN WITH INTERCOURSE _____ YES NO
DATE OF THE LAST PERIOD _____
DATE OF THE LAST MAMMOGRAM _____
TYPE OF BIRTH CONTRAL USED _____
NUMBER OF PREGNANCIES _____
NUMBER OF FULL TERM BIRTHS _____

SKIN – INTEGUMENT

DRYNESS _____ YES NO
ITCHING _____ YES NO
RASH _____ YES NO
SENSITIVE SKIN _____ YES NO
HIVES _____ YES NO
ECZEMA/PSORIASIS _____ YES NO
VARICOSE VEINS _____ YES NO
EASY BRUISING _____ YES NO

PT/CLIENT SIGNATURE:
X _____
GUARDIAN SIGNATURE:
X _____
DATE; _____/_____/_____