Health History Questionnaire

(Appendix to the PDI)

NAME ____ AGE _________________

ADDRESS ____ SEX ___________

DATE OF BIRTH ______________________________ PHONE ___________________

OCCUPATION ____

TODAY'S DATE ____________ EDUCATION ________________________________

List all current medications and daily dosage. Please include all medicines: prescriptions and over-the-counter (e.g., laxatives, birth control, aspirin, cold or allergy sprays, diet pills, etc.).

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How much of the following do you consume on an average day?
Coffee _______________ Tea _______________ Soft drinks _______________

1. Have you ever had surgery that required anesthesia? **Yes / No**
Please list them and include dates:

____
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____
____
____

2. Are you currently being treated by a physician? **Yes / No**
For what medical problem(s)?

____
____
____

3. Have you had any of the following?
Nausea or vomiting (recently) **Yes / No**
High Temperature/Fever (recently) **Yes / No**
High Blood Pressure **Yes / No**
Diabetes **Yes / No**
Cancer (what type?) ________________________________ **Yes / No**
Epilepsy or seizures **Yes / No**
Concussion or other head injury **Yes / No**
Stroke **Yes / No**

Multiple Sclerosis **Yes / No**
Parkinson's disease **Yes / No**

4. Have you had any recent weight or appetite changes? **Yes / No**

5. Do you have any problems with your heart?
Mitral valve prolapse **Yes / No** Open heart surgery **Yes / No**
Congestive heart failure **Yes / No** Palpitations **Yes / No**
Angina **Yes / No**

6 Have you ever been treated for liver or kidney problems?
Hepatitis **Yes / No** Cirrhosis **Yes / No** Dialysis **Yes / No**

7. Do you have respiratory or breathing difficulties?
Asthma **Yes / No** Emphysema **Yes / No** Pneumonia **Yes / No**

8 Have you ever lost control of your bowels or bladder? **Yes / No**

9. Have you had any recent sexual problems? **Yes / No**
[Men] problems having or maintaining an erection? **Yes / No**
[Men] problems with ejaculation? **Yes / No**
[Men and Women] recent difficulties achieving orgasm? **Yes / No**

10. [Women] Have you had any recent menstrual changes? **Yes / No**
Do you menstruate regularly? **Yes / No**

11. Have you had any problems with speech? **Yes / No**
Slurring words? **Yes / No**
Difficulty remembering the names of common things? **Yes / No**

12. Have you had any changes in your vision? **Yes / No**
Double vision? **Yes / No** Blurry vision? **Yes / No**
Temporary blindness? **Yes / No** Tunnel vision? **Yes / No**
Visual hallucinations or distortions? **Yes / No**

13. Have you ever blacked out or had no recollection of recent events? **Yes / No**

14. Do you experience headaches? **Yes / No** Please describe them.

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____
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____
____

Are they new or different from previous headaches? **Yes / No**

15. Have you hit your head recently? **Yes / No**

16. Is there a spot on your head that is sensitive to touch? **Yes / No**

17. Do you have pain or stiffness in your neck? **Yes / No**

18. Have you noticed any changes in your walking? **Yes / No**

19. Do you get dizzy or lose your balance easy? **Yes / No**

20. Have you had difficulties with your coordination? **Yes / No**

21. Do your hands tremble sometimes? **Yes / No**

22. Has your handwriting changed? **Yes / No**

23. Are you unusually sensitive to heat and cold? **Yes / No**

24. Do you have any allergies? **Yes / No**
To what are you allergic? ____

25. Do you have strong cravings for particular food? **Yes / No**

26. Do you often feel fatigued, lethargic, or ill between meals? **Yes / No**

27. Have you had any persistent rashes? **Yes / No**

28. have you recently had any unusual hair loss? **Yes / No**

29. have there been any changes in your sleep pattern? **Yes / No**
Early morning awakenings? **Yes / No** Excessive tiredness? **Yes / No**
Difficulty falling asleep? (insomnia) **Yes / No**

30. Have you or others noticed any change in any of the following?
Personality or emotions? **Yes / No**
Memory? (amnesia) **Yes / No**
Work performance? **Yes / No**

31. Do you sometimes find yourself laughing or crying for no apparent reason?
Yes / No

32. Have your sensory responses (sight, touch, taste, hearing, smelling) ever been distorted, exaggerated, or diminished? **Yes / No**

33. Have you ever sensed (seen, heard, tasted, smelled) something that you think only you sensed and not others who were around you? **Yes / No**

34. Have you recently had a feeling that you had experienced a situation or had been someplace, although you actually experiencing it for the first time? (deja vu) **Yes / No**
35. Have you had any thoughts that just seem to go on and on and you couldn't stop?
Yes / No

36. Has drinking alcohol ever interfered with your job or personal relationships?
Yes / No
What is your alcohol consumption per week? ________________________________

37. In the past six months have you used street drugs or other drugs for non-medical reasons? (e.g., narcotics, cocaine, barbiturates, marijuana) **Yes / No**