HEALTH QUESTIONNAIRE

Name: ________________________ DOB: ____________________________

Date: _____________________ PHN: _______________________

This brief questionnaire is about your health. It will assist us in determining your ability to participate in our program. This information is confidential.

1. Do you have any serious health problems or *illnesses (such as tuberculosis or active pneumonia)* that may be contagious to others around you? If yes, please give details.

No Yes

2. Have you ever had a stroke? If yes, please give details.

No Yes

3. Have you ever had a head injury that resulted in a period of loss of consciousness? If yes please, give details

No Yes

4. Have you ever had any form of seizures, delirium tremens or convulsions? If yes, please explain.

No Yes

5. Have you experienced or suffered any chest pains? If yes, please give details.

No Yes

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6. Have you ever had a heart attack or any problem associated with the heart? If yes, please give details.

No Yes

7. Do you take any medications for a heart condition? If yes, please give details.

No Yes

8. Have you ever had blood clots in the legs or elsewhere that required medical attention? If yes, please give details.

No Yes

9. Have you ever had high-blood pressure or hypertension? If yes, please give details.

No Yes

10. Do you have a history of cancer? If yes, please give details.

No Yes

11. Do you have a history of any other illness that may require frequent medical attention? If yes, please give details.

No Yes

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12. Do you have any allergies to medications, food, animals, chemical, or any substance? If yes, please give details.

No Yes

13. Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation? If yes, please give details.

No Yes

14. Have you ever been diagnosed with diabetes? If yes, please give details, including insulin, oral medications, or special diet.

No Yes

15. Have you ever been diagnosed with any type of hepatitis or other liver illness? Please give details.

No Yes

16. Have you ever been told that you had problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease? If yes, please give details.

No Yes

17. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If yes, please give details.

No Yes

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18. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidneys or bladder? If yes, please give details.

No Yes

19. Do you have any of the following: arthritis, back problems, bone injuries, muscle injuries, or joint injuries? If yes, please give details.

No Yes

20. Please describe any surgeries or hospitalization due to illness or injury that you have had.

21. When was the last time you saw a physician? What was the purpose of the visit?

22. Do you take any prescription medications including psychiatric medications? If yes, please list

No Yes

23. Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen? If yes, please list the medication(s) and how often you take it.

No Yes

24. Do you take over the counter digestive medications such as Tums or Maalox? List the medication

No Yes

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25. Do you wear or need to wear glasses, contact lenses, or hearing aids? If yes, please give details.
No Yes

26. When was your last dental exam?

27. Are you in need of dental care? If yes, please give details.
No Yes

28. Do you wear or need to wear dentures or other dental appliances that may require dental care? If yes, please give details.
No Yes

Client Signature: ______________________________ Date: ______________________________