



OCCUPATION: \_\_\_\_\_

HOBBIES: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

MARITAL STATUS (CIRCLE ONE):

Single      Live with Partner      Married      Separated      Divorced      Widowed

DO YOU CONSUME ALCOHOLIC BEVERAGES? (CIRCLE ONE)

NEVER      RARELY      MODERATELY      DAILY

DO YOU SMOKE CIGARETTES? YES NO      PACKS PER DAY \_\_\_\_\_ YEARS SMOKED \_\_\_\_\_

ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT? (CIRCLE ONE) YES NO N/A

**PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:**

|  | YES | NO |                               | YES | NO |
|--|-----|----|-------------------------------|-----|----|
| General weakness                       |     |    | Abnormal bowel movements      |     |    |
| Leg Cramping                           |     |    | Frequent urination            |     |    |
| Numbness                               |     |    | Unable to urinate             |     |    |
| Shortness of breath                    |     |    | High blood pressure           |     |    |
| Swelling of hands, feet or ankles      |     |    | Chest pain or angina          |     |    |
| Weakness of muscles or joints          |     |    | Stroke                        |     |    |
| Any difficulty walking                 |     |    | Heart surgery                 |     |    |
| Pain in calves or buttocks             |     |    | Heart disease                 |     |    |
| If yes, is that pain relieved by rest? |     |    | Cardiovascular disease        |     |    |
| History of falls or poor balance       |     |    | Epilepsy/Seizures             |     |    |
| Decreased sensation in arms or legs    |     |    | Kidney disease                |     |    |
| Numbness in arms or legs               |     |    | Lung disease                  |     |    |
| Psychiatric care                       |     |    | Fevers                        |     |    |
| Depression                             |     |    | Emphysema/Bronchitis          |     |    |
| Chemical dependency (alcohol/drugs)    |     |    | Gout                          |     |    |
| Hepatitis                              |     |    | Arthritis                     |     |    |
| Weight Loss                            |     |    | Diabetes                      |     |    |
| Thyroid problems                       |     |    | Varicose Veins                |     |    |
| Dizziness/Fainting                     |     |    | Irritable Bowel Syndrome      |     |    |
| Cancer                                 |     |    | Stomach Ulcer                 |     |    |
| Family history of cancer               |     |    | Disruption in sleeping habits |     |    |
| Allergies                              |     |    | Hearing loss                  |     |    |
| Please specify:<br>_____               |     |    |                               |     |    |

IS THERE ANY OTHER CONDITION YOU WOULD LIKE TO TELL THE DOCTOR ABOUT?

**Please sign below to confirm that the information presented in this questionnaire is accurate:**

Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_