Patient:	Health Evaluation Questionnaire

/ / 0
D M Y

Confidential Health History

D M Y
Date: _____/_____/_____

(Mr. Mrs. Dr. Ms. Miss) D M Y

Patient: ______________________________Age: _____ Date of Birth: _____/_____/_____

Street Address:______________________ Occupation & Employer: ____________________

____

City: ______________________ Business Phone No. ____________________

Postal Code: ______________________ Home Phone No. ____________________

Please complete the following in detail:

Physician: ______________________ Address: ______________Phone__________

Dentist: ______________________ Address: ______________Phone__________

Referred by: ______________________ Address: ______________Phone__________

Occupation: ______________________

Person Financially Responsible for This Account: (if different from above)

Name: ______________________ Occupation: ____________________

Street Address: ______________________ Name of Spouse: ____________________

City: ______________________ Business Phone No. ____________________

Postal Code: ______________________ Home Phone No. ____________________

In your own words please describe what you feel are your main problems, stating the most important first:

____

____

____

How and when did your problem(s) first begin?

____

____

____

Have you received any injury such as a blow, concussion or whiplash? And if so, when:

____

____

____

Are you restricted in your work or unable to work?

____

____

____

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Whom have you consulted regarding your problems and approximately when?

____

____

____

What treatment have you received to date?

____

____

____

Has it helped?

____

____

____

What medications are you currently taking?

____

____

____

Described how your problem has affected you? (Your life? / Your activity?)

____

____

____

Do you suffer from any of the following conditions? Please circle and note date:

Condition				Condition			
A Heart Ailment	Yes	No	______	Thyroid Disorder	Yes	No	______
Shortness of breath	Yes	No	______	Chest pains	Yes	No	______
Swollen ankles	Yes	No	______	Bruise or bleed abnormally	Yes	No	______
High Blood Pressure	Yes	No	______	Jaundice or Hepatitis	Yes	No	______
Respiratory disease	Yes	No	______	Tuberculosis	Yes	No	______
Diabetes	Yes	No	______	Epilepsy	Yes	No	______
Rheumatic fever	Yes	No	______	Hay fever or Asthma	Yes	No	______
Arthritis	Yes	No	______	Allergies	Yes	No	______
Any Blood Disease	Yes	No	______	Sinusitis	Yes	No	______
Any Liver Disease	Yes	No	______	Anemia	Yes	No	______
Any Kidney Disease	Yes	No	______	Cancer	Yes	No	______
Stomach Ailment	Yes	No	______	Stroke	Yes	No	______
Intestinal disorder	Yes	No	______	Any Venereal disease	Yes	No	______

Any other medical condition we should know about: ________________________________

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We would appreciate your assistance in completing this confidential health evaluation form. The information obtained from you will allow us to assess more accurately the nature of your problem. Where several symptoms are mentioned, please underline or circle those that apply to you.

	Past	Present	Never
Do you notice a burning sensation on your tongue?	☐	☐	☐
Do you notice any impairment of your sense of taste?	☐	☐	☐
Is swallowing difficult for you at times?	☐	☐	☐
Do you have occasional difficulties with speech?	☐	☐	☐
Do you smoke and if so, how many per day?	☐	☐	☐
Do you have earaches? Left side / Right side / Both	☐	☐	☐
Do you notice a buzzing, ringing or whooshing noise in your ears? Frequently / Occasionally / Rarely	☐	☐	☐
Do you notice a loss of hearing?	☐	☐	☐
Do you notice increased sensitivity to noise?	☐	☐	☐
Do you notice fullness, stuffiness or itching of the ears?	☐	☐	☐
Do you ever feel a loss of balance?	☐	☐	☐
Do you ever feel dizzy or nauseous?	☐	☐	☐
Do you ever "black out" temporarily?	☐	☐	☐
Do you experience deep pain behind the eyes?	☐	☐	☐
Do you have a stiff neck or shoulders? Frequently / Occasionally / Rarely	☐	☐	☐
Do you have upper or lower back problems?	☐	☐	☐
Do you have tingling or numbness in the hands or feet?	☐	☐	☐
Do you have joint pains elsewhere in the body?	☐	☐	☐

Where? ____________________

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	Past	Present	Never
Do you suffer from rheumatoid or osteoarthritis?	☐	☐	☐
Do you have very flexible joints throughout the body?	☐	☐	☐
Do you have headaches? If so, Left / Right / Front / Back	☐	☐	☐
Are headaches Dull / Sharp / Throbbing / Piercing / Aching	☐	☐	☐
How frequently do your headaches occur? ______________			
Do your headaches occur most often during: the Morning / Afternoon / Evening?			
Is there anything that seems to cause the headaches? ____			
Do you have clicking or popping noises in your jaw:	☐	☐	☐
Opening your mouth / Closing your mouth / or on Chewing? Left side / Right side / Both			
Does your jaw ever lock when: Trying to Open / or when Fully Open?	☐	☐	☐
Is your jaw sore or stiff when you wake up?	☐	☐	☐
Is there pain or discomfort when you open your mouth?	☐	☐	☐
Do you have difficulty making your teeth fit together?	☐	☐	☐
Do you clench or grind your teeth?	☐	☐	☐
Do you have tooth pain or discomfort in your mouth?	☐	☐	☐
Is it difficult or painful to chew hard foods?	☐	☐	☐
Have you had orthodontic treatment?	☐	☐	☐
Do you have facial pain or discomfort?	☐	☐	☐

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Patient's signature: ______________________________________ Date: _________________