The Dallas Limb
Restoration Center

Health Questionnaire

Circle the items that you have and/or have had in the past

Childhood Diseases

Measles	yes	no	Mumps	yes	no	Rubella	yes	no
Diphtheria	yes	no	Tetanus	yes	no	Polio	yes	no
Small Pox	yes	no	Rheumatic Fever	yes	no	Whooping Cough	yes	no
Scarlet Fever	yes	no	Chicken Pox	yes	no	Meningitis	yes	no

Neurological

Blackouts	yes	no	Seizures	yes	no	Migraine Headaches	yes	no
Concussions	yes	no	Hit in the Head	yes	no	Lymes Disease	yes	no
Brain Surgery	yes	no	Unconscious	yes	no	Epilepsy	yes	no
Dizziness	yes	no	Stroke/CVA/TIA	yes	no	Difficulty Walking	yes	no
Blurred Vision	yes	no	Double Vision	yes	no	Loss of Bowel/Bladder	yes	no

Cardiovascular

Angina	yes	no	Palpitations	yes	no	Arrhythmia	yes	no
Lightheaded	yes	no	Fainting	yes	no	Bypass Surgery	yes	no
High BP	yes	no	Low BP	yes	no	Anemia	yes	no
Heart Disease	yes	no	Pacemaker	yes	no	AICD	yes	no
Mononucleosis	yes	no	Bleeding Tendency	yes	no	Heart Murmur	yes	no

Respiratory

Hayfever	yes	no	Bronchitis	yes	no	Lung Surgery	yes	no
Allergies	yes	no	Emphysema	yes	no	Pulmonary Edema	yes	no
Asthma	yes	no	Wheezing	yes	no	Pneumonia	yes	no
Short of Breath	yes	no	Pulmonary Embolism	yes	no			
Tuberculosis	yes	no	if yes, date of last ppd _____			or last chest xray _____		

Gastro-Intestinal

Reflux	yes	no	Nausea	yes	no	Persistent Vomiting	yes	no
Hiatal Hernia	yes	no	Chronic Diarrhea	yes	no	Lactose Intolerance	yes	no
Peptic Ulcer	yes	no	Chronic Constipation	yes	no	Vomiting Blood	yes	no

Genito-Urinary

Incontinence	yes	no	Discharge	yes	no	Painful Urination	yes	no
▲ Frequency	yes	no	Bladder Infections	yes	no	Venereal Disease	yes	no
Kidney Disease	yes	no	Bloody Urine	yes	no	Kidney Stones	yes	no

Other Illnesses

▲ Thyroid	yes	no	Cataracts	yes	no	Back Trouble	yes	no
▼ Thyroid	yes	no	Rheumatic Arthritis	yes	no	if yes, when _____		
Osteoarthritis	yes	no	Organ Transplant	yes	no	Unexplained weight gain	yes	no
Cancer	yes	no	Hernia R or L	yes	no	Unexplained rashes	yes	no
if yes, type_____			Blood Transfusion	yes	no	Anxiety	yes	no
Sinus Trouble	yes	no	Unexplained weight loss	yes	no	Blood Clots / DVT	yes	no
Hives	yes	no	Hepatitis A B C D E	yes	no	Liver Problems	yes	no
Eczema	yes	no	Glaucoma	yes	no	if yes, type_____		
AIDS/HIV	yes	no	Poor Blood Circulation	yes	no	Depression	yes	no
Diabetes	yes	no	Atherosclerosis	yes	no			
Difficulty Hearing	yes	no	Hemorrhoids	yes	no	Other: _____		

Type of Birth Control Used_____ Are you claustrophobic? yes no

Explain all yes answers except childhood illness

_____

_____

_____

_____

Patient Name_____ Today's Date _____