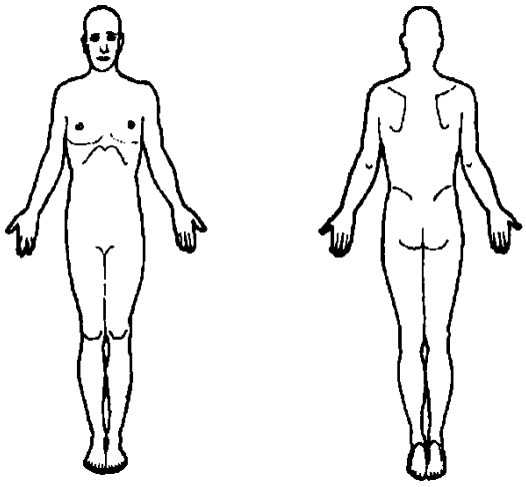
Health History Questionnaire

Patient name _____ **Date** _____

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure ----------Yes --No
2. Hardening of the arteries (arteriosclerosis) ----------Yes --No
3. Diabetes ----------Yes --No
4. Tuberculosis ----------Yes --No
5. Cancer ----------Yes --No
   Where? _____
6. Heart or blood diseases ----------Yes --No
7. Bone spurs on the neck bones (cervical sprain) ----------Yes --No
8. Whiplash injury (flexion-extension injury, cervical sprain) ----------Yes --No
9. Have you or any of your relatives ever suffered a stroke? ----------Yes --No
10. Were you ever a smoker? ----------Yes --No
    From _____ to _____
11. Do you take medication on a regular basis? ----------Yes --No
12. Visual disturbances (blurring, loss, double vision) ----------Yes --No
13. Hearing disturbances (loss, ringing, other noise) ----------Yes --No
14. Slurred speech or other speech problems ----------Yes --No
15. Difficulty swallowing ----------Yes --No
16. Dizziness ---------- --Yes --No
17. Loss of consciousness, even momentary blackouts ----------Yes --No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body? ----------Yes --No
19. Sudden collapse without loss of consciousness ----------Yes --No

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

| 0 1 2 3 4 5 6 7 8 9 10 |

No pain Extreme pain