

# Biophysical®

## Medical History Questionnaire

All questions in this questionnaire are strictly confidential.  
This questionnaire will take approximately 10 minutes to complete.

Today's Date			
Name (Last, First, M.I.)		<input type="checkbox"/> Male	<input type="checkbox"/> Female
DOB (MM/DD/YY)	Age	Height	Weight
Are you taking this test for health screening purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What is your main health concern?			
<b>Personal Health History</b>			
Please describe any symptoms that you are currently experiencing:			
Have you had a fever in the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
For women, is your menstrual period?			
<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular	<input type="checkbox"/> Heavy	<input type="checkbox"/> I am menopausal
Check all health conditions that apply to you:			
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Anemia	<input type="checkbox"/> Digestive Disorders	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Reflux/GERD	
<input type="checkbox"/> Heart Disease/Angina	Type_____	<input type="checkbox"/> Prostate Enlargement/BPH	
<input type="checkbox"/> Stroke	Treatment_____	<input type="checkbox"/> Pulmonary/Respiratory Disorders/Asthma	
<input type="checkbox"/> Allergies/Eczema	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Osteoporosis/Osteopenia	
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Type 1 Diabetes	<input type="checkbox"/> Neurological Disorders	
<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> Type 2 Diabetes	<input type="checkbox"/> Reproductive Disorders or Low Libido	
Type_____	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Major Depression	
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Gout	<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Arthritis/Osteoarthritis		<input type="checkbox"/> Other_____	
Please describe any marked check boxes above:			
<b>Medications</b>			
Prescribed (including birth control, steroid medications, hormone replacement therapy, and allergy shots):			
Over the Counter:			
Vitamins/Supplements:			

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

**Medications Continued**

Have you had any injections in the past month?  Yes  No If yes, what type? \_\_\_\_\_

Have you taken any steroids in the past month (e.g. testosterone, prednisone, cortisone, decadron)?  Yes  No

Are you taking a medication to reduce stomach acid (e.g. Nexium, Prilosec)?  Yes  No

Have you received a hepatitis immunization series?  Yes  No

**Surgeries and Hospitalizations**

Surgeries and hospitalizations. If you have had surgery in the past year, please indicate the month of the surgery.

Year	Reason

If you have had a hysterectomy, were both ovaries removed?  Yes  No  NA

If you have had a prostatectomy, did you have an orchiectomy (removal of testes)?  Yes  No  NA

**Lifestyle**

Alcohol  Never  Rarely  Up to 2 per day  > 2 per day

Tobacco  Never  Quit in \_\_\_\_Year  < 1 pack/day  >1 pack/day

Physical Activity  Sedentary  Occasional  Regular  Athletic training or equivalent

**Family History**

Check all health conditions that have affected family members:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> I am adopted         | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Digestive Disorders                    |
| <input type="checkbox"/> High Cholesterol     | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Prostate Enlargement/BPH               |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Type _____           | <input type="checkbox"/> Pulmonary/Respiratory Disorders/Asthma |
| <input type="checkbox"/> Heart Disease/Angina | <input type="checkbox"/> Type 1 Diabetes      | <input type="checkbox"/> Osteoporosis/Osteopenia                |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Type 2 Diabetes      | <input type="checkbox"/> Neurological Disorders                 |
| <input type="checkbox"/> Thyroid Disease      |   | <input type="checkbox"/> Other _____                            |
| <input type="checkbox"/> Autoimmune Disorder  |   |   |
| Type _____                                    |   |   |

To return this form please FAX to Biophysical Corporation 512.623.4950