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## Health Questionnaire

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

Referred by: \_\_\_\_\_

### I. Personal Information

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status:  Single  Married  Widow(er)  Separated  Divorced Number of children? \_\_\_\_\_

Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_

List work history and dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Education: \_\_\_\_\_ Years of High School \_\_\_\_\_ Years of College \_\_\_\_\_ Years of Post Graduate \_\_\_\_\_

Reason / goal for your visit and treatment: \_\_\_\_\_

\_\_\_\_\_

### II. General Health Information - *(Please bring copies of recent lab)*

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ When last taken: \_\_\_\_\_

When and where did you have your last physical checkup? \_\_\_\_\_

Name of family physician \_\_\_\_\_

Present illness / Main concern (**single** worst): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List other concerns in order of severity: 1. \_\_\_\_\_  
2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Date or age main symptoms began? \_\_\_\_\_

Began where? \_\_\_\_\_

How often do episodes occur? \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Days \_\_\_\_\_ Weeks

How long do they last? \_\_\_\_\_ Minute(s) \_\_\_\_\_ Hours \_\_\_\_\_ Days \_\_\_\_\_ Weeks

Yes  No Free of symptoms? When? \_\_\_\_\_

What factors do you know or suspect from your own experience cause your symptoms or make them worse? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What kind of medical doctors or specialists have you seen for your main complaint?

What was your diagnosis? \_\_\_\_\_

Have you recently been treated by a practitioner of:

- |                              |                             |   |                              |                             |             |                              |                             |             |
|------------------------------|-----------------------------|---|------------------------------|-----------------------------|-------------|------------------------------|-----------------------------|-------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychology  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Homeopathy  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Biofeedback |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteopathy  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Acupuncture |                              |                             |             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chiropractic  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Reflexology |                              |                             |             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kinesiology   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hypnosis    |                              |                             |             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Naturopathy   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nutrition   |                              |                             |             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are there foods that make your symptoms better? Worse? Explain: _____ |                              |                             |             |                              |                             |             |

Yes  No Do you feel better if you skip a meal? \_\_\_\_\_

Yes  No Have you ever fasted? When? \_\_\_\_\_ For How long? \_\_\_\_\_

Yes  No Are there foods you occasionally crave? Explain: \_\_\_\_\_

Yes  No Do you have food allergies? Explain: \_\_\_\_\_  
\_\_\_\_\_

If you could not eat for several days, what food or foods would you miss the most? \_\_\_\_\_  
\_\_\_\_\_

Are most of your meals \_\_\_\_\_ at home \_\_\_\_\_ at restaurants

Please list what you typically eat for:

Breakfast: \_\_\_\_\_  
\_\_\_\_\_

Lunch: \_\_\_\_\_  
\_\_\_\_\_

Dinner: \_\_\_\_\_  
\_\_\_\_\_

Snacks: \_\_\_\_\_ Beverages: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Medications

List all medications you are **now** using; include vitamins, herbs, food supplements, and over the counter medicines.

	Name	Amount	Frequency	How Long
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____
6	_____	_____	_____	_____
7	_____	_____	_____	_____
8	_____	_____	_____	_____
9	_____	_____	_____	_____
10	_____	_____	_____	_____
11	_____	_____	_____	_____
12	_____	_____	_____	_____
13	_____	_____	_____	_____
14	_____	_____	_____	_____

Yes  No Have you taken antibiotics or steroids for more than 1 year?

## Allergy

List any **allergy** or **adverse reaction** to medications, injections, herbs or vitamins with symptoms:

Drug	Symptom	Drug	Symptom

## Surgical History

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Studies: Check items that apply. In the recent past, have you had any of the following studies:

- Yes  No X-rays of the sinuses? If yes, when? \_\_\_\_\_
- Yes  No X-rays of the chest? If yes, when? \_\_\_\_\_
- Yes  No X-rays of the stomach, gallbladder, or colon? If yes, when? \_\_\_\_\_
- Yes  No X-rays of the teeth (dental examinations)? If yes, when? \_\_\_\_\_
- Yes  No Scans of the body, bone or brain? If yes, when? \_\_\_\_\_
- Yes  No Electrocardiogram? If yes, when? \_\_\_\_\_
- Yes  No Hearing tests? If yes, when? \_\_\_\_\_
- Yes  No Blood or urine tests? If yes, when? \_\_\_\_\_
- Yes  No Tuberculin skin test (TB skin test)? If yes, when? \_\_\_\_\_

- Yes  No Colon examination? If yes, when? \_\_\_\_\_  
 Yes  No Bone density? If yes, when? \_\_\_\_\_  
 Yes  No Cholesterol? What level? \_\_\_\_\_  
 Yes  No Flu vaccine? If yes, when? \_\_\_\_\_  
 Yes  No Pneumonia vaccine? When? \_\_\_\_\_  
 Yes  No Tetanus Vaccine? When? \_\_\_\_\_  
 Yes  No Do you have a smoke detector?  Yes  No Do you have a carbon monoxide detector?  
 Yes  No Do you wear your seat belt?  
 Yes  No Do you use sunscreen?  
 Yes  No Do you have an advance directive? Living Will? \_\_\_\_\_ Power of Attorney? \_\_\_\_\_

## Immediate Family

Instructions: Please include all information you know of related to the following areas. You may need to ask your parents for a complete history.

What is your ancestry / ethnicity? \_\_\_\_\_

	Father	Mother	Brother	Sister	Paternal		Maternal	
					Grandfather	Grandmother	Grandfather	Grandmother
Age if living								
Age at death								
Cause of death								
Type of work								
Asthma Allergy Hives Eczema								
Blood clots								
Weight problem								
Tobacco use								
Alcohol abuse								
Mental Illness								
Cancer								
Diabetes								
Hypertension								
Heart problem								
High cholesterol								
Thyroid disease								
Ulcers								
Arthritis								
Other								

### III. Review of Systems

#### Dermatologic

- Yes  No Have you ever had eczema? If so, when last? \_\_\_\_\_
- Yes  No Do you tend to have dandruff?
- Yes  No Fungus?
- Yes  No Is your skin dry?
- Yes  No Do you have herpes?
- Yes  No Do your nails split easily?

#### Ears, Nose, Throat

- Yes  No Do you have ringing or buzzing in your ears?
- Yes  No Do you have hay fever? Is this worse with: \_\_\_\_\_ Seasons \_\_\_\_\_ Animals \_\_\_\_\_ Dust \_\_\_\_\_ Mold
- Yes  No Do you have postnasal drip?
- Yes  No Have you had nasal polyps?
- Yes  No Have you had sinus infections? When last? \_\_\_\_\_
- Yes  No Hearing Aid?
- Yes  No Do you have any decayed or painful teeth?
- Yes  No Do you have bleeding gums?
- Yes  No Do you have persistent sores in your mouth?
- Yes  No Do you have trouble swallowing foods?
- Yes  No Do you often have hoarseness?
- Yes  No Do you floss everyday?
- Yes  No Do you have fillings in your teeth? Which type? \_\_\_\_\_

#### Eyes

- Yes  No Dryness?
- Yes  No Sensitive to light?
- Yes  No Wear glasses or contacts?
- Yes  No Glaucoma?
- Yes  No Cataracts?
- Yes  No Macular degeneration?
- Yes  No Difficulty seeing at night?

#### Headaches

- Yes  No Migraine? Check items associated with headache:
- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus?   | <input type="checkbox"/> Loss of sight          | <input type="checkbox"/> Light sensitivity  | <input type="checkbox"/> Vomiting             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tension? | <input type="checkbox"/> Dazzling lights        | <input type="checkbox"/> Visual disturbance | <input type="checkbox"/> Neck / Shoulder pain |
|   | <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Noise sensitivity  | <input type="checkbox"/> Flushing             |
|   | <input type="checkbox"/> Tender or painful skin | <input type="checkbox"/> Queasy stomach     | <input type="checkbox"/> Chilly sensation     |
|   | <input type="checkbox"/> Tearing of eye         | <input type="checkbox"/> Abdominal pain     |   |
|   | <input type="checkbox"/> Nasal drip             | <input type="checkbox"/> Nausea             |   |

#### Endocrine

- Yes  No Do you have chronic fatigue?
- Yes  No Do you have insomnia?
- Yes  No Do you obtain 8 hours of sleep each night? If not, how much? \_\_\_\_\_
- Yes  No Have you lost or gained more than ten pounds in the last year?
- Yes  No Can you gain or lose four or five pounds in a day?
- Lowest adult weight \_\_\_\_\_ Lbs \_\_\_\_\_ Age
- Highest adult weight \_\_\_\_\_ Lbs \_\_\_\_\_ Age
- Yes  No How much would you like to weigh? \_\_\_\_\_ Lbs
- Yes  No Have you ever had thyroid trouble? Low? \_\_\_\_\_ High? \_\_\_\_\_
- Yes  No Have you had sugar diabetes?
- Yes  No Have you had hypoglycemia?

## Chest

- Yes  No Have you had asthma? When? \_\_\_\_\_
- Yes  No Have you ever been told you have emphysema or chronic bronchitis, or another disease?
- Yes  No Do you get out of breath easily?
- Yes  No Do you have chest tightness?

## Cardiovascular

- Yes  No Have you recently had episodes of chest pain lasting more than one minute?
- Yes  No Have you ever had a heart attack?
- Yes  No Have you had an abnormal EKG?
- Yes  No Does your heart race or skip?
- Yes  No Have you had a heart murmur?
- Yes  No Have you had swelling in your feet or ankles?
- Yes  No Do you have high blood pressure?
- How far can you walk vigorously before becoming short of breath? \_\_\_\_\_

## Gastrointestinal

- Yes  No Were you ever treated for ulcers?
- Yes  No Have you taken antacids regularly?
- Yes  No Have you had black bowel movements?
- Yes  No Have you had blood in your stools, even in small amounts?
- Yes  No Have you ever had yellow jaundice or hepatitis?
- Check symptoms that apply:
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heartburn       | <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Belch frequently |
| <input type="checkbox"/> Bloating        | <input type="checkbox"/> Flatulence          | <input type="checkbox"/> Stomach aches    |
| <input type="checkbox"/> Cramping        | <input type="checkbox"/> Queasy Stomach      | <input type="checkbox"/> Constipation     |
| <input type="checkbox"/> Use laxatives   | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Anal itching     |
| <input type="checkbox"/> Mucus in stools | <input type="checkbox"/> Gallbladder trouble | <input type="checkbox"/> Hemorrhoids      |
| <input type="checkbox"/> Nausea          | <input type="checkbox"/> Abdominal pain      |   |

## Urinary

- Yes  No Do you usually have to get up at night to urinate? How many times? \_\_\_\_\_
- Yes  No Do you void only small amounts of urine each time you go?
- Yes  No Is it hard to get urination started?
- Yes  No Do you lose urine when you cough or sneeze?
- Yes  No Have you had bladder or kidney infections in the past five years?
- Yes  No Have you ever had kidney stones?
- Sexual Preference:  Male  Female  Both

## Men Only

- Yes  No Discharge from penis?
- Yes  No Sores on penis or scrotum?
- Yes  No Lump or pain in testicle(s)?
- Yes  No Do you have a decrease in libido?
- Yes  No Are your erections less strong?
- Yes  No Inability to achieve or sustain an erection?
- Yes  No Prostate exam? If yes, when? \_\_\_\_\_ PSA when? \_\_\_\_\_

## Hematology

- Yes  No Have you had a low white blood count?
- Yes  No Have you ever been anemic? (Had low red blood count.)
- Yes  No Have you taken iron pills previously?

- Yes  No Do you bruise easily?
- Yes  No Have you noticed swelling of lymph glands in your neck, armpits or groin lately?
- Yes  No Have you had blood clots?

**Skeletal**

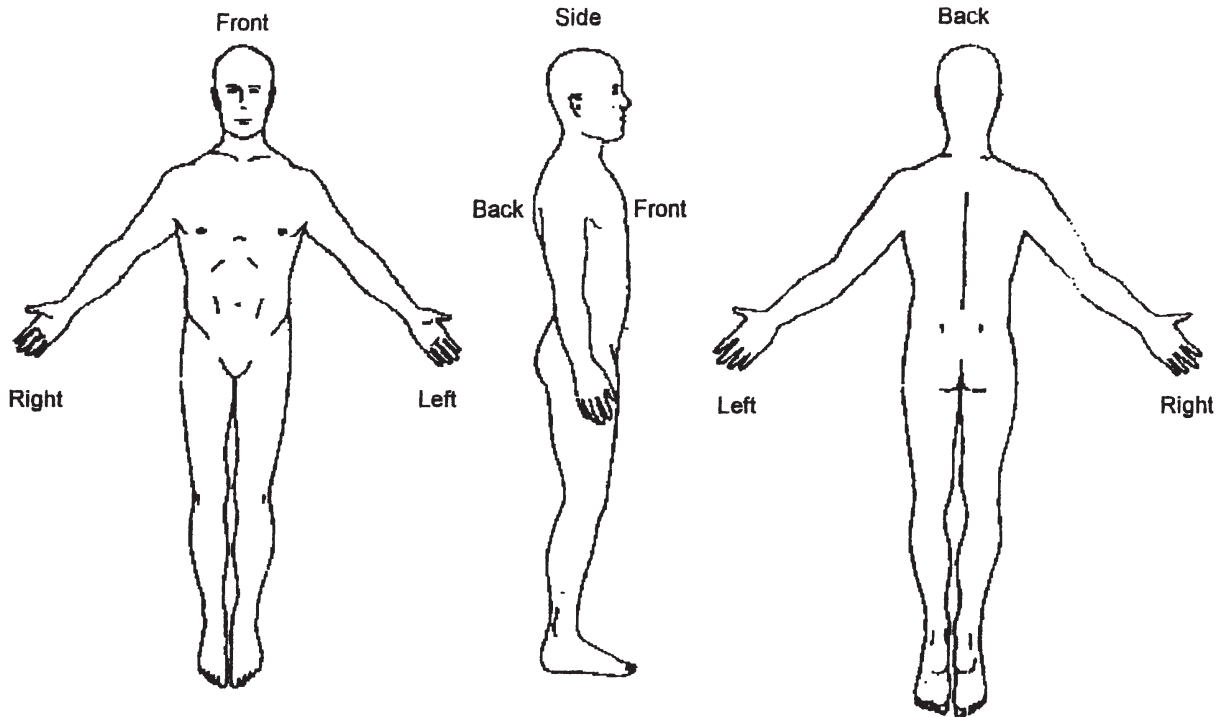
- Yes  No Do you have arthritis? What kind? \_\_\_\_\_
- Yes  No Do your bones hurt?
- Yes  No Have you ever had gout?
- Yes  No Do you have muscle spasms?
- Yes  No Do you have muscle pain?
- Yes  No Do you experience muscle fatigue?
- Yes  No Do you experience restless legs?

**Neurology**

- Yes  No Have you had head injuries?
- Yes  No Have you ever had blackout spells? If so, when? \_\_\_\_\_
- Yes  No Have you ever had seizures (convulsions)? If so, when? \_\_\_\_\_
- Yes  No Have you ever lost your ability to speak?
- Yes  No Are there times when you have trouble thinking clearly or explaining what you mean?
- Yes  No Were you ever told you had learning disabilities or dyslexia?
- Yes  No Do you have trouble with school?

**Headache, Nerve, Muscular or Skeletal Pain**

Yes  No Please color on the picture where you have pain or other symptoms. Include symptoms of pain, numbness or tingling.



## Personal Habits

Do you consider your health to be:  Excellent  Good  Fair  Poor

### Exercise

How often do you exercise?  At least 3 times a week  Occasionally  Rarely  Never

If you exercise, what do you do? \_\_\_\_\_

For how long and how often? \_\_\_\_\_

### Tobacco Use

Yes  No

Do you currently smoke cigarettes?

If yes, how many per day? \_\_\_\_\_ When did you start? \_\_\_\_\_

How do you feel about quitting smoking? \_\_\_\_\_

If you do not currently smoke cigarettes, have you ever smoked?  Yes  No

If yes, when did you start? \_\_\_\_\_ How many per day? \_\_\_\_\_ When did you stop? \_\_\_\_\_

Do you use any other type of tobacco?  Yes  No If yes, what? \_\_\_\_\_

### Caffeine Use

Yes  No

Do you consume drinks with caffeine (coffee, tea, soda)? If yes, how many drinks each day? \_\_\_\_\_

### Alcohol and Drug Use

Yes  No

Do you drink alcohol? If yes, how many drinks do you have each week? \_\_\_\_\_

Yes  No

Do you ever have a drink in the morning to help you get going?

Yes  No

Have you ever tried to cut down on your drinking?

Yes  No

Have you ever felt guilty about the amount you drink?

Yes  No

Have you ever been an alcoholic?

Yes  No

Do you use recreational drugs?

### Abuse

Yes  No

Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

Yes  No

Within the last year, has anyone ever forced you to have sexual activities?

Yes  No

Do you feel you are verbally or emotionally abused by someone?

Yes  No

Have you had counseling for these issues?

### Stress Management

What are the current major stressors or life changes in your life? \_\_\_\_\_

Yes  No

Any major changes in family health during the past year?

If yes, explain: \_\_\_\_\_

How do you handle stress?  Very well  Moderately well  Poorly

What do you do to relax? \_\_\_\_\_

Yes  No

Is your hostility easily aroused?

Yes  No

Do you show aggressive impatience with anyone or anything that delays you?

Yes  No

Do you generally have several projects going at the same time?

Yes  No

Do you set unreasonable deadlines?

Yes  No

Do you get enough leisure time?

Yes  No

Do you have financial problems?

Yes  No

Are you usually happy?

Yes  No

Are there problems at home? With:  Partner  Children  Parents  In-laws  Others

Yes  No

Do you have too many responsibilities?

Yes  No

Are you a victim of domestic abuse, either physical or verbal?

Yes  No

Is anyone at home sick with a chronic disease?

Yes  No

Is your job satisfying to you?

Yes  No

Is your job upsetting you?

Yes  No

Are you usually satisfied with medical advice?

Yes  No

Do you often have nightmares?

Yes  No

Do you feel blue or sad?

Yes  No

Do you have periods of worry or feeling tense?

Yes  No

Do you feel depressed or lonely?

Yes  No

Do you have crying spells?

Yes  No

Do you have cable or dish TV? How many hours per week do you watch TV? \_\_\_\_\_