Vine
Homecare & Staffing

HEALTH QUESTIONNAIRE – MEDICAL HISTORY

Name: _____ Date: _____

Address: _____ Phone #: _____
_____

Date of Birth: _____ Height: _____ Weight: _____

Indicate by checking any diseases or illnesses you have or have had:

_____ Asthma _____ Allergies _____ Arthritis _____ HBP

_____ Back Cond. _____ Fatigue _____ Joint Pain _____ LBP

_____ Bursitis _____ Ulcers _____ Heart Cond. _____ Sinus

_____ Hernia _____ Epilepsy _____ Eye Cond. _____ TB

_____ Diabetes _____ Hearing _____ Anxiety _____ Vertigo

_____ Paralysis _____ Migraines _____ Depression _____ Thyroid

_____ Drug Use _____ Alcohol Use _____ Bronchitis _____ Pneumonia

_____ SOB _____ Skin Rashes _____ Hay fever _____ Weight Loss

_____ HIV _____ Hernia

Have you ever been hospitalized for any of the above or had surgery? Explain:
_____
_____
_____

Have you ever had an industrial accident? Explain:
_____
_____