Light Quest WORKSHOPS

Lighten Your Heart!

Medical Questionnaire

General Information

Name: _____

Address: _____ Day/Cell Phone: _____

City/St/Zip: _____ Evening Phone: _____

Emergency Contact: _____ Relation to You: _____

Phone: _____

Physician: _____ Phone: _____

Do you have health insurance? Yes ___ NO ___

Insurance Company: _____ Phone: _____

Address: _____ Policy Number: _____

_____

Height: _____ Weight: _____ Age: _____ Date of Birth: _____

[redacted] Phone: [redacted] Fax: [redacted]

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Medications

Are you taking **any** medications as prescribed by a Medical Doctor? Yes ___ No ___

If yes, please list below:

Medication	How much/how often	Reason for Meds	Side Effects
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Medical Allergies

Have you experienced any allergic reactions to any medications? Yes ___ No ___

If yes, please list medications and reactions below:

Medication	Reaction
1.	
2.	
3.	
4.	
5.	
6.	
7.	

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Medical History

Do you have, or have you ever had, any of the following conditions or symptoms? Please specify **Yes** or **No** for each condition.

	Yes	No		Yes	No		Yes	No
1. Vision Impairment	___	___	19. Difficulty Urinating	___	___	38. Learning Disability	___	___
2. Hearing Impairment	___	___	20. Kidney Problems	___	___	39. Frequent Dizziness	___	___
3. High Blood Pressure	___	___	21. Obesity	___	___	40. Frequent Fainting	___	___
4. Heart Disease	___	___	22. Arthritis	___	___	41. Diabetes	___	___
5. Heart Murmur	___	___	23. Broken Bones	___	___	42. Hypoglycemia	___	___
6. Elevated cholesterol	___	___	24. Neck or Back Problems	___	___	43. Eating Disorders	___	___
7. Irregular Heartbeat	___	___	25. Joint Problems	___	___	44. Thyroid Problems	___	___
8. Family History of			26. Muscle Cramps	___	___	45. Endocrine or Gland		
Heart Attacks	___	___	27. Tuberculosis	___	___	Problems	___	___
9. Circulation Problems	___	___	28. Exposure to Tuberculosis	___	___	46. Unexplained Weight		
10. Chest Pain/Pressure	___	___	29. Recurrent Lung Infections	___	___	Loss	___	___
11. Heart Palpitations	___	___	30. Active Hepatitis	___	___	47. Bleeding Disorder	___	___
12. Shortness of Breath	___	___	31. History of Hepatitis B or C	___	___	48. Blood Disorder/Anemia	___	___
13. Chronic Cough	___	___	32. HIV+ or AIDS	___	___	49. Sickle Cell Dis. Or Trait	___	___
14. Asthma	___	___	33. Unexplained Sweating	___	___	50. Cancer	___	___
15. Ulcers	___	___	34. Seizure Disorder	___	___	51. Skin Problems		
16. Intestinal Problems	___	___	35. Seizure during past year	___	___	52. Special Dietary Needs	___	___
17. Heartburn	___	___	36. Headaches	___	___	53. Medical Equip./Devices	___	___
18. Bladder Infections	___	___	37. Significant Head Injury	___	___	54. Special Physical Req.	___	___
						55. Psychiatric/Emotional problems	___	___
Have you ever been hospitalized for any reason? Yes ____ No ____						56. Other	___	___

If you have answered "Yes to any of the above items, please explain below:

[redacted]

Detailed Responses

- What specific symptoms are occurring?
- How often symptoms/conditions occur?
- How long symptom/conditions last?
- How you care for the symptoms/conditions?
- How symptoms/conditions restrict your activity?
- Date of last occurrence?

ITEM NUMBER	DETAILED RESPONSE

-Thank You-