About Backs & Bones Medical History Questionnaire

Patient Name:		**Date of Birth:**	
Address:		**Home Tel:**	
		Mobile Tel:	
		Email:	
		Occupation:	
GP Surgery:		**Status:**	☐ Single, ☐ Married, ☐ Divorced, ☐ Partner, ☐ Widowed
Current Medication		**Children:**	
		Measurements:	**Height** **Weight**
		Habits:	☐ **Smoke** ☐ **Alcohol** ☐ **Drugs**
How did you hear about us?		**Daily Activities, hobbies**	

Please tick the following if applicable. *Please expand overleaf after completing this side of the questionnaire

- ☐ Generally fit and healthy
- ☐ Suffering from a medical condition*
- ☐ Seen by any medical practitioner recently*
- ☐ Received any major or minor surgery*
- ☐ Ever been involved in an accident*
- ☐ Any unexplained weight loss/gain
- ☐ History of Cancer*
- ☐ Long term fatigue
- ☐ Recent change in bladder or bowel habits
- ☐ Difficulty walking
- ☐ Any numbness or tingling
- ☐ Recent Fever
- ☐ Night sweats
- ☐ Changes/Difficulty in vision, hearing, taste or smell

Do you have (or have you ever had) any of the following medical conditions or symptoms?

- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Heart Attack or heart disease
- ☐ Swollen and/or painful calves
- ☐ Stroke
- ☐ High Blood Cholesterol
- ☐ Anaemia

- ☐ Frequent Headache or Migraine
- ☐ Fainting, dizziness, poor balance
- ☐ Loss of consciousness
- ☐ Epilepsy or seizures
- ☐ Muscle weakness
- ☐ Tremors
- ☐ Anxiety
- ☐ Depression

- ☐ Kidney/Bladder infection
- ☐ Increased frequency urinating
- ☐ Pain or difficulty urinating

- ☐ Long term coughing
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Emphysema OR Bronchitis
- ☐ Pneumonia OR Tuberculosis
- ☐ Sinusitis

- ☐ Allergies or Intolerances
- ☐ Skin rashes
- ☐ Eczema, Dermatitis or Psoriasis
- ☐ Easily bruised

- ☐ Thyroid disorder
- ☐ Diabetes
- ☐ Osteoporosis or osteopenia

- ☐ Arthritis or swollen joints
- ☐ Restricted movement
- ☐ Fractured bones

- ☐ Heartburn, acid reflux or ulcers
- ☐ Stomach discomfort/pain
- ☐ Gallbladder problems
- ☐ Liver disorder, hepatitis, cirrhosis
- ☐ Diarrhoea or Constipation
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Blood in stools or black stools

Women Only

- ☐ Menopause
- ☐ Very painful or heavy periods
- ☐ Irregular periods
- ☐ Currently pregnant or trying to conceive
- ☐ Previously pregnant
- ☐ Premenstrual Syndrome (PMS)

Men Only

- ☐ Prostate problems

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If possible please outline below any medical conditions, operations received or accidents		
Date/Year	**Condition**	**Outcome**

At times it is necessary to contact you, either about your appointment, or to check how you are getting on. Please indicate the best way to contact you:

Phone □

Email □

Post □

We also may offer discounts at times or have events you may be interested in. If you are happy for us to contact you about these, please tick □.

We do not give any of your details to third parties without your permission.