Hernando Orthopaedic & Spinal Surgery

Michael W. Higgins, D.O., P.A

Client Information

Name ______________________ Ht.______ Wt.______ Age______

Address_____________________ City______State____ Zip_______

D.O.B.____________ Social Security Number (optional)___________

Home Phone______________ Work Phone___________Fax_______

Employment____

Family Physician____________________Cardiologist_____________

Health Questionnaire
Self-Assessment

What is Your Body Telling You?

Thyroid/Parathyroid (Glandular System)

Are you overweight?	Yes	No
Do you get cold hands and feet	Yes	No
Do you have hair loss or are you bald or going bald?	Yes	No
Is it east to put on weight or hard to lose it?	Yes	No
Are your fingernails ridged, brittle or weak?	Yes	No
Do you have varicose or spider veins?	Yes	No
Do you or have you had hemorrhoids?	Yes	No
Do you get cramping in your muscles?	Yes	No
Is your bladder strong or weak?	Strong	Weak

Thyroid/Parathyroid (Glandular System) Continued

Do you have an irregular heartbeat?	Yes	No
Do you have Mitral Valve Prolapse (heart murmur)?	Yes	No
Do you get headaches or migraines?	Yes	No
Do you or have you had a hernia?	Yes	No
Have you ever had an aneurysm?	Yes	No
Do you have osteoporosis?	Yes	No
Do you have scoliosis?	Yes	No
Do you get irritable easy?	Yes	No
Do you have low energy levels?	Yes	No
Do you suffer from symptoms of depression?	Yes	No
Did you score low on your bone density tests?	Yes	No
Does your test come back showing Low Calcium levels?	Yes	No
Do you or have you ever had a goiter?	Yes	No
Do you have spine deterioration or herniated discs?	Yes	No
Have you been diagnosed with Hashimoto or Reidel Disease? (Or any family member)?	Yes	No
Do you sweat profusely of hardly at all?	Yes	No
Nervous/anxiety	Yes	No
Hand tremors	Yes	No
Insomnia	Yes	No

Thyroid/Parathyroid (Glandular System) Continued

Palpitations/skipped heart beats?	Yes	No
Excessive sweating?	Yes	No
Sensitivity to heat, overheating easily?	Yes	No
Weight loss	Yes	No
Diarrhea	Yes	No
Warm hand and feet	Yes	No
Oily skin and hair	Yes	No
Fatigue	Yes	No
Weight gain easily	Yes	No
Low body temperature	Yes	No
Muscle weakness	Yes	No
Constipation	Yes	No
Coarse, dry skin and hair	Yes	No
Puffy face and swollen eyelids	Yes	No
Depression	Yes	No
Memory loss	Yes	No
Eyebrows thinner on the sides	Yes	No

AadrenGlands (Glandular System)
Medulla (Adrenal)

Do you have M.S., Parkinson's or Palsy	Yes	No
Do you have anxiety attacks or feel overly anxious?	Yes	No
Do you feel excessive shyness or inferior to others?	Yes	No
Do you have low blood pressure (below 11 systolic)?	Yes	No
Do you have tremors, nervous legs, etc.?	Yes	No
Do you have tinnitus (ringing in the ears)?	Yes	No
Do you have S.O.B. (shortness of breath) or is it hard to take a deep breath?	Yes	No
Do you have heart arrhythmias?	Yes	No
Do you have trouble sleeping?	Yes	No
Do you have Chronic Fatigue Syndrome?	Yes	No
Do you get tired easily?	Yes	No
Have you been diagnosed with Addison's Disease Or with Congenital Adrenal Hyperplasia?	Yes	No

Cortex (Adrenal)

Do you have elevated blood cholesterol levels?	Yes	No
Do you have lower back weakness?	Yes	No
Do you have or have you had sciatica?	Yes	No
Do you have arthritis or bursitis?	Yes	No
Do you have any "it is's" (inflammatory conditions)?	Yes	No

Explain:____

Female Only

Are your menstruations irregular?	Yes	No
Do you have excessive bleeding during menstruation?	Yes	No
Do you have or have you had ovarian cysts?	Yes	No
Do you have or have you had fibroids?	Yes	No
Do you have or have you had endometriosis or A-typical cells?	Yes	No
Are you fibrocystic?	Yes	No
Do you have fibromyalgia or scleroderma?	Yes	No
Do you get sore breasts, especially during menstruation?	Yes	No
Do you have a low or excessive sex drive?	Yes	No
Have you had a hysterectomy?	Yes	No

When?________________ Partial_______ Complete_______

Did they take any other organs out at the same time?	Yes	No
Have you had a D & C?	Yes	No
Have you had a miscarriage ?	Yes	No

How many? ___________

Have you had difficulty conceiving?	Yes	No

Male Only

Do you have prostatitis (frequent urination esp. night)?	Yes	No

How often_____________________________

Do you have prostate cancer?	Yes	No

PSA Count’s __________

Male Only (Continued)

Do you have testicular hypertrophy (enlargement)?	Yes	No
Do you have a low or excessive sex drive?	Yes	No
Do you have erection problems?	Yes	No
Do you have premature ejaculations?	Yes	No

Pancreas

Do you get gas after you eat?	Yes	No
Do you feel your foods just sitting in your stomach?	Yes	No
Do you have Acid Reflux?	Yes	No
Do you see any indigested food in your stool?	Yes	No
Do you have hypoglycemia (low blood sugar)?	Yes	No
Do you have Diabetes (high blood sugar)? Type 1______ Type 11______	Yes	No
Are you thin and have a hard time gaining weight?	Yes	No
Do you have gastritis or enteritis?	Yes	No
Do you have foods pass right through you (diarrhea)?	Yes	No
Do you have moles on your body?	Yes	No

Gastro-Intestinal Tract

Is your tongue coated, especially in am? (white, yellow, green or brown)	Yes	No
Do you have a Hiatus Hernia?	Yes	No
Do you have Gastritis?	Yes	No

Gastro-Intestinal Tract (Continued)

Question		
Do you have Enteritis?	Yes	No
Do you have Colitis?	Yes	No
Do you have diverticulitis?	Yes	No
Do you have Diarrhea?	Yes	No
How often do you have a bowel movement?	____________________	
Have you ever had stomach or intestinal ulcers?	Yes	No
Do you or have you ever had any type of gastrointestinal Cancers(stomach, colon, rectal, etc.)?	Yes	No

Explain:____

Question		
Have you seen blood in your stool?	Yes	No
Do you have foul smelling stools?	Yes	No
Do you have abdominal pains?	Yes	No
Do you have Crohn’s Disease?	Yes	No
Do you have “gas” problems?	Yes	No

Other GI problems____

Question		
Have you seen blood in your vomit?	Yes	No
Do you have frequent indigestion?	Yes	No
Do you regularly use antacids?	Yes	No
Do you suffer from excessive gas or bloating?	Yes	No

Liver/Gallbladder/Blood

Do you have a problem digesting fats?	Yes	No
Do fats or dairy foods cause bloating and/or pain in The stomach area?	Yes	No
Are your tools white or very light in color?	Yes	No
Do you get pain in the middle of your back? (especially after eating)?	Yes	No
Do you get pain behind the right lower rib area?	Yes	No
Do you have "liver" or brown spots on your skin? (not freckles)	Yes	No
Do you have any skin pigmentation changes?	Yes	No
Do you have skin problems? Explain:____	Yes	No
Are you anemic?	Yes	No
Do you have or every had Hepatitis? A_____ B_____C______	Yes	No

Heart & Circulation

Do you have any grey hair?	Yes	No
Do you have a hard time remembering things?	Yes	No
Do your legs get tired or cramp after walking?	Yes	No
Do you bruise easy?	Yes	No
Do you get chest pains or angina?	Yes	No
Have you ever had a heart attack?	Yes	No

Heart & Circulation (Continued)

Question			
Have you ever had open heart surgery?		Yes	No
Do you have heart arrhythmia's? Type ________________		Yes	No
Do you have a heart murmur or Mitral Valve Prolapse?		Yes	No
Do you ever feel pressure on your chest?		Yes	No
Do you get "prickly" pains anywhere, especially the heart area? Where?________________________		Yes	No
Do you have or ever had High Blood Pressure?		Yes	No
Your average Blood Pressure is ___________ over ___________			
Do you notice chest pains when you exercise?		Yes	No
Have you noticed a marked drop in your Ability to exercise?	No	Sometimes	Often
Do you have indigestion?	No	Sometimes	Often
Do you lose consciousness or pass out?	No	Sometimes	Often
Are you lightheaded or dizzy?	No	Sometimes	Often
Does your heart miss or skip beats?	No	Sometimes	Often
Do you notice your heart beating rapidly at times?	No	Sometimes	Often

Skin

Question		
Do you get skin rashes?	Yes	No
Do you get skin blemishes?	Yes	No
Do you have Eczema or Dermatitis?	Yes	No
Do you have Psoriasis?	Yes	No

Skin (Continued)

Do you itch anywhere? Explain____	Yes	No
Is your skin dry?	Yes	No
Is your skin excessively oily?	Yes	No
Do you have Dandruff?	Yes	No
Are you allergic to anything? Explain____	Yes	No
Do you ever get colds or flu-like symptoms?	Yes	No
Do you have sinus problems?	Yes	No
Do you have or get sore throats?	Yes	No
Do you have swollen lymph nodes?	Yes	No
Do you have or had tumors? Fatty______ Benign______Cancerous_______ Where________________	Yes	No
Do you have a low platelet count?	Yes	No
Is your immune system low or sluggish?	Yes	No
Have you had appendicitis or an appendectomy? When___________________	Yes	No
Do you get boils, pimples and the like?	Yes	No
Do you have allergies?	Yes	No
Have you ever had abscesses?	Yes	No
Have you ever had toxemia?	Yes	No

Skin (Continued)

Question		
Do you have of have you had Cellulitis?	Yes	No
Have you ever had Gout?	Yes	No
Do you get blurred vision?	Yes	No
Do you have mucus in your eyes when you wake in the am?	Yes	No
Do you snore?	Yes	No
Do you have sleep apnea?	Yes	No
Have you had your tonsils removed? What age?_______________	Yes	No

Kidneys & Bladder

Question		
Have you ever had a urinary tract infection (UTI)?	Yes	No
Have you ever had burning upon urination?	Yes	No
Do you have problems holding your bladder?	Yes	No
Have you ever had kidney stones?	Yes	No
Do you get cramping or pain on either side of your Mid-to-lower back?	Yes	No
Do you or did you ever have Nephritis?	Yes	No
Do you or did you every have Cystitis?	Yes	No

Lungs

Question		
Do you have or have had Bronchitis?	Yes	No
Do you have or have had Emphysema?	Yes	No
Do you have or have had Asthma?	Yes	No

Lungs (Continued)

Do you have or have had COPD?	Yes	No
Are you on inhalers or nebulizers? What type________________ How often__________________	Yes	No
Do you know what your Oxygen saturation is?	Yes	No
Do you get pain when you breathe?	Yes	No
Do you get pain when you take a deep breath?	Yes	No
Do you or have you had lung cancer?	Yes	No
Do you have a collapsed lung?	Yes	No
Are you a smoker? Amount___________________	Yes	No
Have you ever had Pneumonia?	Yes	No
Have you ever worked around toxic chemicals, in Coal mines or around asbestos?	Yes	No
Do you cough a lot?	Yes	No
Do you produce mucus when you cough? What color_______________________	Yes	No
Do you suffer from shortness of breath?	Yes	No
Do you have swelling of your ankles?	Yes	No
Do you prop yourself up with pillow when you sleep?	Yes	No
Do you wheeze?	Yes	No
Do you have upper restpitory infections?	Yes	No

Lungs (Continued)

Question		
Do you cough up blood or blood tinged phlegm?	Yes	No

Muscle and Bones Part 1

Symptom				
Muscles are smaller and harder to build	No	Mild	Moderate	Severe
Pot Belly	No	Mild	Moderate	Severe
Deep forehead wrinkles	No	Mild	Moderate	Severe
When exercises, gets fatigued easier than Before	No	Mild	Moderate	Severe
Sagging cheeks	No	Mild	Moderate	Severe
Lips are thinner	No	Mild	Moderate	Severe
Longer to recover after exercise	No	Mild	Moderate	Severe
Thinner skin	No	Mild	Moderate	Severe
Unable to lose fat with diet and exercise	No	Mild	Moderate	Severe
Flabby muscles	No	Mild	Moderate	Severe

Muscle and Bones Part 2

Question			
Do you suffer from joint pain?	No	Sometimes	Often
Have you noticed your joints swelling?	No	Sometimes	Often
Do you suffer from arthritis?	No	Sometimes	Often
Do you have back pains or back problems?	No	Sometimes	Often
Do you have limited flexability?	No	Sometimes	Often
Do you have muscle spasms?	No	Sometimes	Often

Muscle and Bones Part 2

Do you notice tingling or numbness in your hands?	No	Sometimes	Often

Brain Part 1

Do you suffer from headaches?	No	Sometimes	Often
Do you have fainting spells?	No	Sometimes	Often
Do you suffer from seizures?	No	Sometimes	Often
Do you ever have tremors?	No	Sometimes	Often
Do you find yourself dizzy?	No	Sometimes	Often
Do you have problems with your balance?	No	Sometimes	Often
Do you feel weak?	No	Sometimes	Often
Have you noticed problems speaking?	No	Sometimes	Often
Have you noticed it is harder to remember things?	No	Sometimes	Often
Have noticed it is harder to concentrate?	No	Sometimes	Often

Brain Part 2

Memory loss	No	Sometimes	Often
Joint pain	No	Sometimes	Often
Difficult handling stress	No	Sometimes	Often
See colors less brightly	No	Sometimes	Often
Does not appreciate art as much anymore	No	Sometimes	Often
Abundant light colored urine	No	Sometimes	Often

Brain Part 3

Trouble falling asleep	No	Sometimes	Often
Wake up during the night	No	Sometimes	Often

Brain Part 3 (Continued)

If awakened, cannot fall back to sleep	No	Sometimes	Often
Racing thoughts while trying to fall asleep	No	Sometimes	Often
Does not feel rested in the morning	No	Sometimes	Often
Use medication or alcohol to fall asleep	No	Sometimes	Often

Sex Part 1

Aggressiveness	No	Sometimes	Often
Increased sex drive	No	Sometimes	Often
Oily hair and skin	No	Sometimes	Often
Acne	No	Sometimes	Often
Increased body and facial hair	No	Sometimes	Often
Overly developed muscular physique	No	Sometimes	Often

Sex Part 2

Muscles are smaller/weaker	No	Sometimes	Often
Increased fat	No	Sometimes	Often
Lower self confidence/self esteem	No	Sometimes	Often
Decreased sex drive	No	Sometimes	Often
Fatigue	No	Sometimes	Often
Loss of body and pubic hair	No	Sometimes	Often

Sex Part 3

Increased appetite	No	Sometimes	Often
Crave sugar and sweets	No	Sometimes	Often
Weight gain	No	Sometimes	Often
Fatigue	No	Sometimes	Often
Drowsy in the morning	No	Sometimes	Often

Sex Part 4

Snoring	No	Sometimes	Often
Trouble Sleeping	No	Sometimes	Often
Depression	No	Sometimes	Often
Joint aches and pains	No	Sometimes	Often
Strange/weird dreams	No	Sometimes	Often
Bloated/water retention	No	Sometimes	Often
Headaches	No	Sometimes	Often

Sex Part 5

Bloated/water retention	No	Sometimes	Often
Weight gain especially in the hips, abdomen And thighs	No	Sometimes	Often
Swollen and tender breast	No	Sometimes	Often
Irritable, nervous or anxious	No	Sometimes	Often

Sex Part 5 (Continued)

Frequent headaches	No	Sometimes	Often
Trouble sleeping	No	Sometimes	Often
Joint aches/pains	No	Sometimes	Often
Heavy or prolonged periods	No	Sometimes	Often

Sex Part 6

Hot flashes	No	Sometimes	Often
Night sweats	No	Sometimes	Often
Poor memory	No	Sometimes	Often
Depression	No	Sometimes	Often
Breasts are smaller and droopy	No	Sometimes	Often
Thinning skin	No	Sometimes	Often
Urinary leakage	No	Sometimes	Often
Vaginal dryness	No	Sometimes	Often
Painful intercourse	No	Sometimes	Often
Lack of energy	No	Sometimes	Often
Irregular periods/no periods	No	Sometimes	Often
Mood swings	No	Sometimes	Often

What are your health complaints or concerns?

Please list any conditions or symptoms that have not been covered or asked

Past surgeries

List all surgeries and surgery dates

Chemical Medications

List all current chemical medications and reasons for taking

Natural Supplements

List all current natural supplements

Allergies

Genetic History

Mom ____

Dad____

Grandmother (M)____

Grandfather (M)____

Grandmother (P)____

Grandfather (P)____

Brother____

Brother____

Sister____

Sister____

Thank You