Anna Shawcross
OSTEOPATHY

Medical Questionnaire

Patient's name: _____

Patient's Date of Birth: _____

Date: _____

Have you seen an osteopath before? YES ☐ NO ☐

Do you suffer from or have suffered from any of the following conditions?

High or low blood pressure?	YES	☐	NO	☐
Stroke/Transient Ischemic Attack?	YES	☐	NO	☐
Diabetes?	YES	☐	NO	☐
Epilepsy?	YES	☐	NO	☐
Cancer?	YES	☐	NO	☐
Tumours?	YES	☐	NO	☐
Osteoporosis?	YES	☐	NO	☐
Osteoarthritis?	YES	☐	NO	☐
HIV/AIDS?	YES	☐	NO	☐

Please give details of any internal metal pins, wires, special equipment or artificial joints?

_____
_____
_____

Please let me know if you have recently or in the past experienced any of the following:

Cardiovascular System

Chest pains or palpitations	YES	☐	NO	☐
Cold hands for feet	YES	☐	NO	☐
Swollen ankles	YES	☐	NO	☐
Pains in legs on walking	YES	☐	NO	☐
Varicosities	YES	☐	NO	☐

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Respiratory System

Shortness of breath ……..	YES	☐	NO	☐
Cough with sputum ……..	YES	☐	NO	☐
Wheezing ……..	YES	☐	NO	☐
Chest pain on breathing ……..	YES	☐	NO	☐

Gastrointestinal Tract

Do you have a good appetite ……..	YES	☐	NO	☐
Do you eat a normal diet that includes meat ……	YES	☐	NO	☐
Abdominal discomfort ……..	YES	☐	NO	☐
Do you have a normal bowel habit ……	YES	☐	NO	☐
Regular nausea or vomiting ……	YES	☐	NO	☐

Genito-urinal Tract
Need to ask about passing urine

Any changes frequency/Colour/Smell ……	YES	☐	NO	☐
Pain on urination ……	YES	☐	NO	☐

Neurological

Any changes hearing, sight, smell ……	YES	☐	NO	☐
Fits, faints, blackouts ……	YES	☐	NO	☐
Dizziness or vertigo ……..	YES	☐	NO	☐
Mood changes ……	YES	☐	NO	☐
Headache ……...	YES	☐	NO	☐

Dermatological / Allergies

Skin conditions ……..	YES	☐	NO	☐
Rashes, itches, bruising ……..	YES	☐	NO	☐

Thank you!