

HEALTH HISTORY INVENTORY

HHI-4

Name or I.D. : _____ Date: _____

Please check an "X" mark in the boxes () below for those items that apply to you.

1. Health History: Have you ever been *diagnosed* by a licensed health care practitioner for any of the following?

- | | | |
|--|--|---|
| <input type="checkbox"/> Tension Headaches | <input type="checkbox"/> Coronary Disorder or Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Migraine or Cluster Headaches | <input type="checkbox"/> Asthma, Bronchitis, or Emphysema | <input type="checkbox"/> Tuberculosis or Pneumonia |
| <input type="checkbox"/> TMJ Disorder or Jaw Pain | <input type="checkbox"/> Liver Disease or Hepatitis | <input type="checkbox"/> Brain Seizures or Epilepsy |
| <input type="checkbox"/> Low Back Pain or Sciatica | <input type="checkbox"/> Urinary or Bladder Disorder | <input type="checkbox"/> Concussion or Head Trauma |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Kidney Disorder or Stones | <input type="checkbox"/> Cancer or Tumors |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Gall Bladder Disorder or Stones | <input type="checkbox"/> AIDS or HIV Disease |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Irritable Bowel Syndrome or Colitis | <input type="checkbox"/> Multiple Sclerosis or Palsy |
| <input type="checkbox"/> Tremors or Tics | <input type="checkbox"/> Hypertension / High Blood Pressure | <input type="checkbox"/> Polio or Mononucleosis |
| <input type="checkbox"/> Tendonitis or Bursitis | <input type="checkbox"/> Hemorrhoids or Hernia | <input type="checkbox"/> Allergies or Hayfever |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Bone Fracture or Joint Sprain | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Anorexia or Bulimia |
| <input type="checkbox"/> Radiculopathy | <input type="checkbox"/> Dysmenorrhea or Irregular Menses | <input type="checkbox"/> Attention Deficit Disorder |
| <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Peri-Menstrual Syndrome (PMS) | <input type="checkbox"/> Panic Attacks or Phobias |
| <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Menopause Problems or Hot Flashes | <input type="checkbox"/> Depression or Bipolar Disorder |
| <input type="checkbox"/> Shingles (Herpes Zoster) | <input type="checkbox"/> Prostate or Genital Disorder | <input type="checkbox"/> Alcohol Abuse Problems |
| <input type="checkbox"/> Dermatitis, Eczema, or Hives | <input type="checkbox"/> Deafness or Tinnitus | <input type="checkbox"/> Substance Abuse Problems |

2. Accidents: Have you ever been left *injured* or *impaired* by any of the following types of accidents?

- | | | |
|--|---|---|
| <input type="checkbox"/> Automobile Accident | <input type="checkbox"/> Work-Related Accident | <input type="checkbox"/> Surgical Complication |
| <input type="checkbox"/> Athletic Injury | <input type="checkbox"/> Accident in Daily Living | <input type="checkbox"/> Medication Side Effect |

3. Current Conditions: In the past 3 months, have you experienced any of the following symptoms?

- | | | |
|---|---|--|
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Chest Pain or Chest Tightness | <input type="checkbox"/> Head Congestion / Runny Nose |
| <input type="checkbox"/> Chronic Back Pain or Sore Back | <input type="checkbox"/> Abdominal Pain or Discomfort | <input type="checkbox"/> Dry Mouth or Dry Throat |
| <input type="checkbox"/> Stiff or Sore Neck and Shoulders | <input type="checkbox"/> Abdominal Distension or Bloating | <input type="checkbox"/> Sore Throats |
| <input type="checkbox"/> Pain in Elbows, Wrists, or Hands | <input type="checkbox"/> Large Weight Gain or Weight Loss | <input type="checkbox"/> Frequent Coughs |
| <input type="checkbox"/> Pain in Hips, Knees, or Feet | <input type="checkbox"/> Overeating or Binge Eating | <input type="checkbox"/> Fever or Malaise |
| <input type="checkbox"/> Stiff, Aching, or Swollen Joints | <input type="checkbox"/> Undereating or Poor Appetite | <input type="checkbox"/> Chills or Aversion to Cold |
| <input type="checkbox"/> Cold Hands or Cold Feet | <input type="checkbox"/> Craving for Sweets | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Frequent Daytime Sweating | <input type="checkbox"/> High Level of Sexual Activity | <input type="checkbox"/> Diarrhea or Loose Stools |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Low Sex Drive | <input type="checkbox"/> Constipation or Dry Stools |
| <input type="checkbox"/> Skin Irritation or Skin Rash | <input type="checkbox"/> Overworked or Overstressed | <input type="checkbox"/> Blurred Vision or Dry Eyes |
| <input type="checkbox"/> Dizziness, Fainting, or Vertigo | <input type="checkbox"/> Poor Memory or Mental Confusion | <input type="checkbox"/> Lethargy, Tiredness, or Fatigue |
| <input type="checkbox"/> Palpitations / Rapid Heart Beats | <input type="checkbox"/> Bored or Uninterested in Things | <input type="checkbox"/> Insomnia or Difficulty Sleeping |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Thoughts of Killing Your Self | <input type="checkbox"/> Disturbing Dreams |
| <input type="checkbox"/> Feeling Restless or Agitated | <input type="checkbox"/> Worried About Finances or Job | <input type="checkbox"/> Feeling Anxious or Afraid |

4. Substances or Medications: In the past 3 months, did you take any of the following items on a daily basis?

- | | | |
|---|--|---|
| <input type="checkbox"/> 5 or more Cigarettes | <input type="checkbox"/> Several Aspirin or Tylenol Type Pills | <input type="checkbox"/> Sleeping Pills |
| <input type="checkbox"/> 4 or more Cups of Coffee | <input type="checkbox"/> Prescribed Pain Reliever Medication | <input type="checkbox"/> Anti-Anxiety Medication |
| <input type="checkbox"/> 3 or more Glasses of Alcohol | <input type="checkbox"/> Blood Pressure Medication | <input type="checkbox"/> Anti-Depressant Medication |