

Name (print): _____ Department/Title: The Starting Point, ASTCI Date: _____

TAY Self Health Questionnaire

Have you had or do you have any disease of the following (check each yes or no) :

	Yes	No		Yes	No		Yes	No		Yes	No
Brain			Lymph Nodes			Sore Throat			Tuberculosis		
Eyes			Genitals			Recurrent Vomiting			Bronchitis		
Nose			Dizziness			Vomiting blood			Nephri		
Throat			Deafness			Chronic constipation			Malari		
Heart			Fainting Spells			Black/bloody b.m.'s			Rheumatic Fever		
Lungs			Chest Pains			Freq/Painful urination			Paralysis		
Stomach			S.O.B.			Blood in urine			Cancer/Tumors		
Intestines			Chronic cough			Swollen ankles			Asthma		
Liver			Coughing up blood			High B/P			Hay Fever		
Spleen			Palpitations			Jaundice			Diabetes		
Galbladder			Allergies			Hernia			Arthritis		
Kidneys			Poor appetite			Stomach ulcers			Rheumatism		
Bladder			Chronic Indigestion			Pneumonia			Nervous breakdown		
Bone			Recurrent nausea			Pleurisy			Painful flat feet		
Joints			Freq. Headaches			Kidney stones			Backaches		
Neck/Spine			Freq. Colds			Piles			Chronic sinus infections		
Skin			Running ears			Convulsions			Injuries		
Ears			Operations						Other serious illnesses		

Do you hear well? Yes No Do you see well? Yes No Weight: _____

Have you ever been diagnosed with a medical condition?

Have you ever had to have a surgery for a medical condition?

Have you ever been rushed to the hospital because of a medical condition?

Please provide details of illnesses, injuries, operations or disabilities:

Women:

Are your menstrual periods regular? Yes No Frequency _____ Duration: _____

Are you currently taking medication? Yes No

If yes please list them:

I certify the above answers are true

Client Signature: _____

Date: _____

Professional assisting with form: _____

Date: _____

Name (print): _____ Department/Title: __The Starting Point, ASTCI_____ Date: _____

Vital Signs:

Blood Pressure: _____

Temperature: _____ Pulse: _____ Respiration: _____

Medical professional taking vitals
(please print and sign)

Date