the wellness bank
INVEST IN YOUR HEALTH

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General Health Questionnaire

Do you currently experience any of these symptoms?

Fevers / chills / sweats	□ Yes	□ No
Unexplained weight loss / gain	□ Yes	□ No
Malaise (feeling generally unwell)	□ Yes	□ No
Unusual fatigue	□ Yes	□ No
Nausea / vomiting	□ Yes	□ No
Headaches	□ Yes	□ No
Dizziness / lightheadedness / loss of consciousness	□ Yes	□ No
Blurred vision	□ Yes	□ No
Numbness / tingling	□ Yes	□ No
Weakness	□ Yes	□ No
Muscle cramping	□ Yes	□ No
Chest pain / palpitations	□ Yes	□ No
Swelling in feet or hands	□ Yes	□ No
Difficulty breathing / shortness of breath	□ Yes	□ No
Difficulty breathing when lying down	□ Yes	□ No
Cough / change in cough/blood in phlegm	□ Yes	□ No
Wheezing	□ Yes	□ No
Difficulty swallowing	□ Yes	□ No
Heartburn / indigestion	□ Yes	□ No
Change in appetite	□ Yes	□ No
Specific food intolerance	□ Yes	□ No
Bowel pattern changes (color, texture, frequency	□ Yes	□ No
Difficulty urinating (starting, stopping)	□ Yes	□ No
Urine frequency changes	□ Yes	□ No
Possibility of pregnancy	□ Yes	□ No

Other Medical Conditions or prior surgeries: _____
_____

Current Medications: _____
_____

Family Medical History (birth parents & siblings): _____
_____
_____