HEALTH QUESTIONNAIRE

Name: _____ Date: _____

Birthdate: _____

Medications

Please list any medications that you currently take regularly (including non-prescription) _____

_____

Allergies

Please list any allergies to medications, foods or other _____

_____

Medical History

Illnesses/Conditions

Do you have or have you ever had any of the following:

		Year
_____	Anemia	_____
_____	Anxiety	_____
_____	Arthritis	_____
_____	Asthma	_____
_____	Birth Defects	_____
_____	Cancer (type:)	_____
_____	Colitis	_____
_____	Concussion	_____
_____	Depression	_____
_____	Diabetes	_____
_____	Emphysema	_____
_____	Heart Attack/Heart Disease	_____
_____	High Blood Pressure	_____
_____	High Cholesterol	_____
_____	Kidney Disease	_____
_____	Liver Disease	_____
_____	Low Blood Sugar	_____
_____	Mitral Valve Prolapse/Murmur	_____
_____	Osteoporosis	_____
_____	Pneumonia	_____
_____	Rheumatic Fever	_____
_____	Seizure Disorder	_____
_____	Sexually Transmitted Disease	_____
_____	Stroke	_____
_____	Thyroid Disorder	_____
_____	Tuberculosis	_____
_____	Ulcer	_____

Surgical Procedures/Hospitalizations Year

_____ _____

_____ _____

_____ _____

_____ _____

Serious Injuries

_____ _____

_____ _____

_____ _____

Childhood Diseases Year

_____ Chickenpox _____

_____ Measles _____

_____ Mumps _____

_____ Polio _____

_____ Other: _____ _____

Gynecological History (women only)

Are you pregnant? _____

Are you breast feeding? _____

Last menstrual period _____

How many pregnancies have you had? _____

How many children do you have? _____

At what age did you start having periods? _____

Family History

Has any blood relative ever had any of the following :

	Relative (mother, father, sister, etc.)
Bleeding problems	_____
Cancer (type)	_____
Convulsions	_____
Diabetes	_____
Heart Attack	_____
Heart Disease	_____
High Blood Pressure	_____
Mental Illness / Suicide	_____
Seizures	_____
Stroke	_____
Other	_____

	Living Age	Deceased Age (at death) & cause
Father	_____	_____
Mother	_____	_____
Brother / Sister	_____	_____
	_____	_____
	_____	_____
Husband / Wife	_____	_____
Son / Daughter	_____	_____
	_____	_____
	_____	_____

Continued on other side →

Health Maintenance continued

When, if ever, did you last have any of the following:

_____ Cholesterol check
_____ Colonoscopy
_____ EKG/Cardiogram
_____ Flu Vaccine
_____ Mammogram
_____ Pap Smear
_____ Prostate exam
_____ Tetanus (Last shot)
_____ Treadmill stress test

Social History

Are you married? **Yes / No**
Do you have children / dependents at home? **Yes / No** *How many?* _____
Are you employed? **Yes / No** *What field?* _____
What is your highest level of education? _____
Do you or have you ever smoked or chewed tobbacco? **Yes / No**
Packs per day _____ */ yrs* _____ *Quit?* _____ *When?* _____
Do you or have you ever used illegal drugs? **Yes / No** *Type:* _____
Do you drink alcohol? **Yes / No** *How much per week?* _____
Have you been exposed to toxic substances? **Yes / No** *What?* _____
Do you drink caffeine daily? **Yes / No** *How much?* _____
Do you exercise regularly? **Yes / No** *Type?* _____
Do you wear seat belts? **Yes / No**
Do you use car seats for your children if under 60lbs.? **Yes / No**
Do you have a living will or advance directives? **Yes / No**

Review of Symptoms

Please circle any of the following that you experience.

General Fatigue Fever Hopelessness Hot flashes Insomnia Night sweats Poor concentration Recent weight loss or gain Loss of interest in usual activities

Skin Change in pigmentation Eczema Hives Jaundice Rashes

ENT Change in vision / hearing Dizziness Englarged glands Glaucoma Headaches Hearing loss Neck stiffness Nose bleeds Chronic sinus or ear problems

Respiratory Asthma Difficulty breathing Frequent colds / coughing Shortness of breath Spitting up blood.

Cardiac Angina Chest pain Difficulty walking 2 blocks Heart murmur High blood pressure Palpitations Swelling of hands / feet

Gastrointestinal Abdominal pain /cramping Blood or dark stool Change in bowel habits Frequent diarrhea Frequent indigestion / heartburn / gas / bloating Hepatitis Hemorrhoids Vomiting blood

Genitourinary Difficulty urinating Frequent urination Loss of bladder control Unsatisfactory sex life

Musculoskeletal Joint pain or swelling Difficulty walking Muscle cramping or weakness Varicose veins

Neuropsychiatric Prior treatment for depression / psychiatric care? Fainting spells Paralysis Convulsions

Hematologic Easy bruising Excessive bleeding after cuts Slowing healing after cuts