

HEALTH QUESTIONNAIRE

NAME: _____ **DATE OF BIRTH:** _____ **PATIENT ID#** _____

REASON FOR VISIT: _____

PAST MEDICAL HISTORY IF YOU OR ANY BLOOD RELATIVE HAVE SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE & INDICATE WHICH RELATIVE

EPILEPSY _____	THYROID _____	OSTEOPOROSIS _____	HIGH CHOLESTEROL _____
MIGRAINE _____	HAYFEVER _____	ARTHRITIS _____	ALCOHOLISM _____
MENTAL ILLNESS _____	ASTHMA _____	HEART DISEASE _____	HEPATITIS _____
GLAUCOMA _____	ANEMIA _____	STROKE _____	CANCER (TYPE) _____
DIABETES _____	BLEEDS EASILY _____	HYPERTENSION _____	OTHER: _____

HOSPITAL ADMISSIONS (NOT INCLUDING PREGNANCIES)

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATION YOU ARE NOW TAKING - INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION.

NAME	DOSE	TIMES/DAY	NAME	DOSE	TIMES/DAY

MEDICAL HISTORY

CHECK MARK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES. CIRCLE ALL CURRENT PROBLEMS.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Decreased hearing
<input type="checkbox"/> Ringing in ear
<input type="checkbox"/> Ear infections (frequent)
<input type="checkbox"/> Dizzy spells
<input type="checkbox"/> Fainting spells
<input type="checkbox"/> Failing vision <input type="checkbox"/> Eye pain
<input type="checkbox"/> Double or blurred vision
<input type="checkbox"/> Nose bleeds (recurrent)
<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Sore throats (frequent)
<input type="checkbox"/> Hoarseness (prolonged)
<input type="checkbox"/> Hayfever / Allergies
<input type="checkbox"/> Pneumonia / Pleurisy
<input type="checkbox"/> Bronchitis/Chronic cough
<input type="checkbox"/> Asthma / Wheezing
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> on exertion <input type="checkbox"/> lying flat
<input type="checkbox"/> Chest pain
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Swollen ankles
<input type="checkbox"/> Irregular pulse
<input type="checkbox"/> Palpitations
<input type="checkbox"/> Leg pain (when walking)
<input type="checkbox"/> Varicose veins / Phlebitis
<input type="checkbox"/> Cold numb feet
<input type="checkbox"/> Loss of appetite (recent)
<input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Heartburn <input type="checkbox"/> Peptic ulcer
<input type="checkbox"/> Persistent nausea / Vomiting
<input type="checkbox"/> Abdominal pain (chronic)
<input type="checkbox"/> Gall bladder trouble
<input type="checkbox"/> Jaundice / Hepatitis
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation
<input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's / Colitis
<input type="checkbox"/> Bloody or tarry stools
<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia
<input type="checkbox"/> Urination - Overactive Bladder
<input type="checkbox"/> More than twice overnight
<input type="checkbox"/> More than 8 times/24 hrs.
<input type="checkbox"/> Urgency to urinate
<input type="checkbox"/> with leakage
<input type="checkbox"/> Leakage with movement
<input type="checkbox"/> Decrease in force/flow
<input type="checkbox"/> Painful
<input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones
<input type="checkbox"/> Urine Infections (frequent)
<input type="checkbox"/> Sexually transmitted diseases
<input type="checkbox"/> Aids / HIV
<input type="checkbox"/> Weight loss
<input type="checkbox"/> Weight gain (recent)
<input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily
<input type="checkbox"/> Blood transfusion
<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes
<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke
<input type="checkbox"/> Tremor/hand shaking | <input type="checkbox"/> Chronic fatigue
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Numbness/tingling
<input type="checkbox"/> Headaches(frequent)
<input type="checkbox"/> Arthritis/Rheumatism
<input type="checkbox"/> Back pain (recurrent)
<input type="checkbox"/> Bone fracture/joint injury
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Foot pain <input type="checkbox"/> Gout
<input type="checkbox"/> Rashes / Hives
<input type="checkbox"/> Psoriasis / Eczema
<input type="checkbox"/> Sleeping difficulties
<input type="checkbox"/> Concentration difficulties
<input type="checkbox"/> Depression
<input type="checkbox"/> Agitation <input type="checkbox"/> Moodiness
<input type="checkbox"/> Nervousness
<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Polio <input type="checkbox"/> Mumps
<input type="checkbox"/> Measles
<input type="checkbox"/> German Measles
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Herpes | <input type="checkbox"/> Alcohol ___ oz.per wk
<input type="checkbox"/> Coffee/Tea
<input type="checkbox"/> ___ cups per day
<input type="checkbox"/> Smoking ___ per day
<input type="checkbox"/> ___ years
<input type="checkbox"/> ___ years quit |
|--|--|---|---|

FEMALES -

Menstrual Flow:
 Reg. Irreg.
 Pain/Cramps
 Days of Flow
 Length of Cycle
 1st day of last cycle:
 Date: _____
 Pain/Bleeding after sex
 Number of:
 Pregnancies
 Abortions
 Miscarriages
 Live Births
 Birth Control Method:
 Name: _____
 Flushing/Menopause
 Last PAP test:
 Date: _____
 Normal Abnormal
 Last Mammogram:
 Date: _____
 Normal Abnormal

ALLERGIES: _____

YEAR OF LAST VACCINE: _____ TETANUS/TD _____ INFLUENZA(FLU) _____ PNEUMONIA _____ HEPATITIS

YEAR OF LAST TEST/EXAM: _____ COLONOSCOPY _____ RECTAL/STOOL _____ CHOLESTEROL
 _____ T.B. TEST _____ HEPATITIS _____ EYE EXAM

NOTES/OTHER _____