

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.)	Living		Deceased
		Age	Age (at death) & cause	
Bleeding problems	_____			
Cancer (type _____)	_____			
Convulsions	_____			
Diabetes	_____			
Heart Attack	_____			
Heart Disease	_____			
High Blood Pressure	_____			
Mental Illness / Suicide	_____			
Seizures	_____			
Stroke	_____			
Other	_____			

Continued on other side →

Health Maintenance continued

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

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

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 tobacco?	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 Enlarged 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