

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 | _____ 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