

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	Deceased
	Age	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