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 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