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		

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

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

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