FAMILY CARE CENTERS HEALTH QUESTIONNAIRE

PATIENT NAME____**DATE**____________________

REASON FOR VISIT:____

FAMILY HISTORY:

If any blood relative has suffered any of the following please circle the number and indicate which relative:

1) Epilepsy	4) Glaucoma	7) Hayfever	10) Easy Bleeding	13) Heart Disease	16) High Cholesterol
2) Migraine	5) Diabetes	8) Asthma	11) Osteoporosis	14) Stroke	17) Alcoholism
3) Mental Illness	6) Thyroid	9) Anemia	12) Arthritis	15) Hypertension	18) Cancer of __________

PERSONAL HISTORY: List Previous Hospital Admissions (not including pregnancies):

Year	Illness or Operation	Hospital	Year	Illness or Operation	Hospital
_____	________________________	_____	________________________		
______	________________________		______	________________________	
______	________________________		______	________________________	

List All Current Medications and Dosage:

(include those you buy without a prescription)

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List Allergies and Adverse Reactions

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List Year of Last Vaccination:

Tetanus / TD___________

Influenza (FLU)________

Pneumonia____________

Hepatitis A____________

Hepatitis B ____________

TB Skin Test___________

(**Please circle all answers Yes or NO. Have you ever had?)**

High Blood Pressure	No	Yes	Nervous Breakdown	No	Yes	Kidney Disease	No	Yes
Low Blood Pressure	No	Yes	Anemia	No	Yes	Gonorrhea or Syphilis	No	Yes
Heart Disease	No	Yes	Epilepsy	No	Yes	Bladder Disease	No	Yes
Diabetes	No	Yes	Meningitis	No	Yes	Scarlet Fever, Scarletina	No	Yes
Tuberculosis	No	Yes	Thyroid Disease	No	Yes	Measles	No	Yes
Influenza	No	Yes	Hay Fever	No	Yes	German Measles	No	Yes
Pleuritis (Pleurisy)	No	Yes	Asthma	No	Yes	Rheumatic Fever	No	Yes
Pneumonitis (Pneumonia)	No	Yes	Hives or Eczema	No	Yes	Chicken Pox	No	Yes
Arthritis or Rheumatism	No	Yes	Migraine Headaches	No	Yes	Diphtheria	No	Yes
Bursitis, Tendonitis	No	Yes	AIDS/HIV	No	Yes	Mumps	No	Yes
Neuritis or Neuralgia	No	Yes	Gallbladder Disease	No	Yes	Small Pox	No	Yes
Any Bone or Joint Disease	No	Yes	Colitis or Other Bowel Disease	No	Yes	Whooping Cough	No	Yes
Sciatica, Back Pain, Lumbago	No	Yes	Jaundice or Liver Disease	No	Yes			
Food, Chemical, Drug Poisoning	No	Yes	Hemorrhoids or Rectal Disease	No	Yes			
Frequent Infections or Boils	No	Yes	Cancer	No	Yes	Type of Cancer:_____________________		

Have you ever had Blood or Plasma Transfusions? No Yes

Have you every been advised to have any surgical or medical treatment which has not been done? No Yes

Do You Drink Alcohol ?	No	Yes	How Much? __________________
Do You Smoke ?	No	Yes	How many cigarettes or cigars per day? ____________________
Do You use Recreational Drugs?	No	Yes	What kind ?___________________

INJURIES: Have you had any of the following

Broken or cracked bones	No	Yes
Dislocations	No	Yes
Concussion, or head injury	No	Yes

What is your weight?: Now _____ One year ago _____ Maximum Weight Ever _____ When________

Date of your last Pap Smear_____________________**Date of your last Mammogram**________________________

Physician Notes:

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