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HEALTH QUESTIONNAIRE

Name _____ Age _____ Date _____

Address _____ Phone _____

City, State, Zip _____ Birth Date _____

It would be greatly appreciated if you would complete and bring this health questionnaire to your next appointment with your physician. The questionnaire may seem long, but carefully filling it out will allow your doctor to be much more thorough in less time, giving you a better evaluation at less expense. Please mark each question either "yes" or "no" if at all possible. If uncertain how to answer it, place a question mark (?) after it. Please fill in the blanks or write "N/A" for not applicable. Brief notes may be written in the margins.

CHIEF COMPLAINT In a few words, list the major reason(s) you are consulting a physician. If more than one, list in order of importance. We will discuss this in detail during your visit.

_____
_____
_____
_____

When was your last complete physical exam? _____
What was done and what were the results? _____
_____

PAST HISTORY List all significant illness, injuries, hospitalizations (except normal pregnancy) and surgery. Start with earliest.

Year	Illness	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had:

- ❑ Measles
- ❑ Whooping Cough
- ❑ Rheumatic Fever
- ❑ Fluid in Chest
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Venereal Disease
- ❑ Phlebitis
- ❑ Mumps
- ❑ Diptheria
- ❑ Scarlet Fever
- ❑ Pleurisy
- ❑ Heart Disease
- ❑ Malaria
- ❑ Pelvic Infection
- ❑ Gout
- ❑ Chickenpox
- ❑ Poliomyelitis
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Hepatitis
- ❑ Diabetes Mellitus
- ❑ Back Pain

MEDICATIONS What medications are you now taking? Don't forget such things as aspirin, cortisone, blood pressure medication, thyroid, tranquilizers, hormones, birth control pills, laxatives, vitamins (do they contain iodine), etc.

Medicine	Dose	Average Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any others taken in the last 6 months not noted above.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

	If living, age & health	If deceased, age at death and cause
Father		
Mother		
Brother/Sister		
Spouse		
Children		

Has any blood relative ever had:			List Relative
Cancer	❑ No	❑ Yes	
Tuberculosis	❑ No	❑ Yes	
Diabetes	❑ No	❑ Yes	
Heart Trouble	❑ No	❑ Yes	
High Blood Pressure	❑ No	❑ Yes	
Stroke	❑ No	❑ Yes	
Convulsions	❑ No	❑ Yes	
Suicide or Mental Disorder	❑ No	❑ Yes	
Bleeding Tendency	❑ No	❑ Yes	
Asthma, Hives or Hay fever	❑ No	❑ Yes	

SOCIAL HISTORY

circle one Single Married Separated Divorced Widowed Number of previous marriages _____

How is your relationship with your spouse? _____

Is your sex life satisfactory? ❑ Yes ❑ No

How is your relationship with your children? _____

What is your occupation? _____ Number of hours worked per week _____

Highest education obtained _____

Do you now smoke? ❑ Yes ❑ No Type and how much _____

Did you ever smoke? ❑ Yes ❑ No How much? _____ For how long? _____

How many cups of coffee do you drink per day? _____ cups

How much alcohol do you drink? (Kind, average frequency and amount) _____

Did you ever drink more than listed above? ..... ❑ No ❑ Yes

Have you ever been drinking without eating for one or more days? ..... ❑ No ❑ Yes

Do you miss much time from work? ..... ❑ No ❑ Yes

IMMUNIZATIONS Have you had the basic immunization series of:

1. Diptheria and Tetanus (DT or DPT) ..... ❑ No ❑ Yes Booster in the last 10 years? ❑ No ❑ Yes _____ (year)
2. Polio: have you had an initial series of 3 oral (Sabin) or injections (Salk) plus a booster 6-12 months later? ❑ No ❑ Yes
3. Have you had mumps or its vaccine? ..... ❑ No ❑ Yes
4. Smallpox ..... ❑ No ❑ Yes
5. Have you had influenza vaccine? ..... ❑ No ❑ Yes
6. For women where pregnancy is possible: Have you had Rubella (German Measles) or its vaccine? ❑ No ❑ Yes
7. If you answered "No" on any question 1-3, your immunization is deficient; do you want it brought up-to-date? ❑ No ❑ Yes

SYSTEM REVIEW

GENERAL

Do you eat a well balanced diet? ❑ No ❑ Yes

Approximate weight 5 years ago _____ 6 months ago _____ Now _____

(note: Past means any time prior to six months ago; Now means any time in the last six months)

HEAD

Eye disease or injury	❑ Never	❑ Past	❑ Now
Double vision	❑ Never	❑ Past	❑ Now
Headaches (circle one on each line)	❑ Never	❑ Past	❑ Now
rarely occasionally frequently			
minimal moderate severe			
Glaucoma	❑ Never	❑ Past	❑ Now
Last year checked for glaucoma _____			
Itching eyes or nose	❑ Never	❑ Past	❑ Now
Hay fever, sneezing or runny nose	❑ Never	❑ Past	❑ Now

Nosebleeds ..... ❑ Never ❑ Past ❑ Now
Sinus trouble ..... ❑ Never ❑ Past ❑ Now
Ear disease ..... ❑ Never ❑ Past ❑ Now
Impaired hearing ..... ❑ Never ❑ Past ❑ Now
Ringing in ears ..... ❑ Never ❑ Past ❑ Now
Severe dizziness or unconsciousness ..... ❑ Never ❑ Past ❑ Now
Seizures or convulsions ..... ❑ Never ❑ Past ❑ Now
Numbness or paralysis ..... ❑ Never ❑ Past ❑ Now
Fainting spells ..... ❑ Never ❑ Past ❑ Now

NECK
Stiffness ..... ❑ Never ❑ Past ❑ Now
Enlarged glands ..... ❑ Never ❑ Past ❑ Now
Injury ..... ❑ Never ❑ Past ❑ Now

RESPIRATORY
Spitting of blood ..... ❑ Never ❑ Past ❑ Now
Chronic cough (including "smoker's cough") ..... ❑ Never ❑ Past ❑ Now
Do you cough up phlegm? ..... ❑ Never ❑ Past ❑ Now
Color _____ How much? _____
Asthma or wheezing ..... ❑ Never ❑ Past ❑ Now
Shortness of breath ..... ❑ Never ❑ Past ❑ Now
How many blocks can you walk without having to catch your breath? _____
Night sweats ..... ❑ Never ❑ Past ❑ Now
Skin tests for tuberculosis ..... ❑ Yes ❑ No
If yes, year tested and results _____
Year of last chest X-ray _____ Normal? ❑ Yes ❑ No

CARDIOVASCULAR
Chest pain or angina pectoris ..... ❑ Never ❑ Past ❑ Now
Shortness of breath when lying flat ..... ❑ Never ❑ Past ❑ Now
Any heart trouble ..... ❑ Never ❑ Past ❑ Now
Ankles often badly swollen ..... ❑ Never ❑ Past ❑ Now
Heart murmur ..... ❑ Yes ❑ No
Rapid, hard or skipped heartbeats ..... ❑ Never ❑ Past ❑ Now
Have you had an EKG? ..... ❑ Yes ❑ No
Year _____ Normal ❑ Yes ❑ No

GASTROINTESTINAL
Peptic ulcer ..... ❑ Never ❑ Past ❑ Now
When _____
Heartburn or indigestion ..... ❑ Never ❑ Past ❑ Now
Sour taste in mouth or throat ..... ❑ Never ❑ Past ❑ Now
Use of Rolaids, Tums, Maalox, Gelusil, soda or other antacids? ..... ❑ Never ❑ Past ❑ Now
Ever vomited blood? ..... ❑ Never ❑ Past ❑ Now
Do foods stick in throat? ..... ❑ Never ❑ Past ❑ Now
Gallbladder trouble ..... ❑ Never ❑ Past ❑ Now
Intolerance to greasy foods ..... ❑ Never ❑ Past ❑ Now
Do you often vomit? ..... ❑ Never ❑ Past ❑ Now
Liver trouble ..... ❑ Never ❑ Past ❑ Now
Crampy abdominal pain ..... ❑ Never ❑ Past ❑ Now
Chronic constipation ..... ❑ Never ❑ Past ❑ Now
Frequent diarrhea ..... ❑ Never ❑ Past ❑ Now
Change in bowel habits ..... ❑ Never ❑ Past ❑ Now
Bloody or black bowel movements ..... ❑ Never ❑ Past ❑ Now
Hemorrhoids or piles ..... ❑ Never ❑ Past ❑ Now

GENITOURINARY
Loss of urine when cough or sneeze ..... ❑ Never ❑ Past ❑ Now
Kidney or bladder infection ..... ❑ Never ❑ Past ❑ Now
When _____
Burning or painful urination ..... ❑ Never ❑ Past ❑ Now
Frequent urination ..... ❑ Never ❑ Past ❑ Now
How often? _____
Do you have to get up at night to urinate? ..... ❑ Never ❑ Past ❑ Now
How many times? _____ For how many years? _____
Feeling that you must go immediately? ..... ❑ Never ❑ Past ❑ Now

Blood in urine ..... ❑ Never ❑ Past ❑ Now
Kidney stones ..... ❑ Never ❑ Past ❑ Now
Swelling of hands and feet ..... ❑ Never ❑ Past ❑ Now
Difficulty starting urination ..... ❑ Never ❑ Past ❑ Now
Decrease in strength of stream ..... ❑ Never ❑ Past ❑ Now

MUSCULOSKELETAL
Significant Arthritis ..... ❑ Never ❑ Past ❑ Now
Varicose Veins ..... ❑ Never ❑ Past ❑ Now
Weakness ..... ❑ Never ❑ Past ❑ Now
Difficulty walking ..... ❑ Never ❑ Past ❑ Now
Pain in calves or buttocks on walking, relieved by rest ..... ❑ Never ❑ Past ❑ Now

SKIN
Frequent infections ..... ❑ Never ❑ Past ❑ Now
Skin disorders (list in margin if yes) ..... ❑ Never ❑ Past ❑ Now

EMOTIONAL
Do you have trouble sleeping? ..... ❑ Never ❑ Past ❑ Now
Are you usually tired? ..... ❑ Never ❑ Past ❑ Now
Are you often depressed? ..... ❑ Never ❑ Past ❑ Now
Are you often anxious or nervous? ..... ❑ Never ❑ Past ❑ Now
Do you have a goal or purpose in life? ..... ❑ Never ❑ Past ❑ Now
Do you ever wish you were dead and away from it all? ..... ❑ Never ❑ Past ❑ Now
Do you have a fear or dread of death or the future? ..... ❑ Never ❑ Past ❑ Now
Do you often worry? ..... ❑ Never ❑ Past ❑ Now
Have you ever been advised to, or been under psychiatric or psychological care? ..... ❑ Never ❑ Past ❑ Now

HEMATOLOGIC
Anemia ..... ❑ Never ❑ Past ❑ Now
Excessive bleeding or abnormal bruising ..... ❑ Never ❑ Past ❑ Now

ENDOCRINE
Hormone therapy ..... ❑ Never ❑ Past ❑ Now
Thyroid disease ..... ❑ Never ❑ Past ❑ Now
Intolerance to slightly warm rooms ..... ❑ Never ❑ Past ❑ Now
Intolerance to slightly cool rooms ..... ❑ Never ❑ Past ❑ Now
Changes in texture of hair and skin ..... ❑ Never ❑ Past ❑ Now
Change in voice (as an adult) ..... ❑ Never ❑ Past ❑ Now
Crave large amount of fluids ..... ❑ Never ❑ Past ❑ Now
Change in hat, glove or shoe size (as an adult) ..... ❑ Never ❑ Past ❑ Now

ALLERGIES
Are you allergic to any medications? ..... ❑ No ❑ Yes

Drug	Reaction
_____	_____
_____	_____

Do you have any (circle): food allergies, asthma, hives, hay fever, or childhood eczema? ❑ Never ❑ Past ❑ Now
Any other illness, symptom or disorder? (list in margin) ..... ❑ Never ❑ Past ❑ Now
Did someone other than the patient help fill this out? ..... ❑ No ❑ Yes
Who? _____

GYNECOLOGICAL (this section for women only)
Age when periods started _____ years old.
Frequency: every _____ days; last period: _____
Are they abnormal or irregular? ..... ❑ Never ❑ Past ❑ Now
Menopausal ..... ❑ Never ❑ Past ❑ Now
At age _____
Number of pregnancies _____ Deliveries _____
Date of last cancer smear _____ Normal ..... ❑ Yes ❑ No
Do you want a pap smear? ..... ❑ Yes ❑ No
Vaginal discharge ..... ❑ Never ❑ Past ❑ Now

Doctor _____ Date _____ Signature of patient _____