HEALTH QUESTIONNAIRE

NAME ______________________ AGE ______ DATE ______

ADDRESS ______________________ PHONE ______

HISTORY OF PAST ILLNESS: Have you had M ______ F ______

Childhood:
☐ Measles ☐ Mumps ☐ Chicken Pox ☐ Congenital Abnormalities ☐ Rheumatic fever or heart disease

Adult:
☐ Asthma ☐ High Blood Pressure ☐ Cancer (Site ______) ☐ Diabetes ☐ Ulcer or Gastritis
☐ Thyroid Problems ☐ Tuberculosis ☐ Kidney Problem ☐ Liver Problems
☐ Blood Problem ☐ Venereal Disease ☐ Heart Failure ☐ Heart Attack ☐ Abnormal Heart Rhythm

Have you had any serious illness? .... No Yes
Have you ever had a transfusion? .... No Yes
Have you ever been hospitalized or been under medical care for very long? .... No Yes
If yes, for what reason? ______

Most recent immunizations: Tetanus ______ (DATE) Hepatitis B ______ (DATE)
Flu Vaccine ______ (DATE) Pneumovax ______ (DATE)

Operations:
Have you had any surgery? .... No Yes
List: ☐ Appendectomy ☐ Hysterectomy (If so, reason: ______) ☐ Ovaries Removed ☐ Joint Replacement
☐ Gallbladder ☐ Bypass (If so, what ______) ☐ Other ______

Medications:
(Dose & frequency) ______ ______ ______
______ ______ ______
______ ______ ______
______ ______ ______

Allergies: Is there a history of skin reaction or allergic reaction following injection or oral administration of:

	Circle One			What Drug or Food?
Penicillin or other antibiotics	Yes	No	Don't Know	
Morphine, Codeine, Demerol or other narcotics	Yes	No	Don't Know	
Novocain or other anesthetics	Yes	No	Don't Know	______
Aspirin, empirin or other pain remedies	Yes	No	Don't Know	______
Sulfa drugs	Yes	No	Don't Know	______
Tetanus antitoxin or other serums	Yes	No	Don't Know	______

Injuries:
Have you ever been seriously injured in a motor vehicle accident? .... No Yes
Have you had any head concussions or injuries? .... No Yes
Have you ever been knocked unconscious? .... No Yes

FAMILY HISTORY:	If Living: Age	Health	If Deceased: Age (at death) & Cause		Has either parent, sister, brother, child, or grandparent ever had?		
Father					Stroke	No	Yes
Mother					Tuberculosis	No	Yes
Brother/Sister					Diabetes	No	Yes
					Heart Trouble	No	Yes
					High blood pressure	No	Yes
					Has any blood relative ever had?		
Husband/Wife					Cancer Type: ______	No	Yes
Son/Daughter					Suicide	No	Yes
					Mental Illness	No	Yes
					Bleeding tendency	No	Yes
					Gout or other crippling arthritis	No	Yes
					Hereditary Defects	No	Yes

SOCIAL HISTORY:
Circle One: Single Married Separated Divorced Widowed Significant Other
With whom do you live? ______
Do you have any problems with sexual function? .... No Yes
Recreational Drug Usage? ______
Foreign travel within last year ______
Coffee ______ Tea ______ Cola's ______ (per day)
Alcoholic Beverages: Never ______ < 1 per week ______ 1-5 per week ______ Other ______
Tobacco: ☐ Never Smoked ☐ Quit ______ years ago ☐ Years smoked ______ ☐ Packs per day ______
Are you employed? Full Time ______ Part Time ______
What is your job? ______
Are you exposed to fumes, dusts or solvents? ______
Education: (Years)
Grade School ______ College ______ Postgraduate ______
Do you wear seatbelts? ☐ Always ☐ Sometimes ☐ Never

How much time have you lost from work because of your health during the past?
Six Months ______ One Year ______ Five Years ______

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[Continued Over]

CHECK ONLY THOSE THAT CURRENTLY APPLY

SYSTEMIC REVIEW: Do you have any of the following?

General: Maximum weight __________ Minimum weight __________

Recent weight change? .... No Yes

Have you been in good general health most of your life? .... No Yes

Have you recently had?

☐ Weakness ☐ Fever ☐ Chills ☐ Night Sweats

☐ Fainting ☐ Problems Sleeping

Skin:

Skin Disease .... No Yes

Jaundice .... No Yes

Hives, eczema or rash .... No Yes

Head-Eyes-Ears-Nose-Throat (cont'd)

Dry eyes or mouth .... No Yes

Bleeding Gums - Frequent or Constant .... No Yes

Blurred Vision .... No Yes

Date of Last Eye Exam __________

Sneezing or runny nose .... No Yes

Nosebleeds - Frequent .... No Yes

Chronic sinus trouble .... No Yes

Ear disease .... No Yes

Impaired hearing .... No Yes

Dizziness or sensation of room spinning .... No Yes

Frequent or severe headaches .... No Yes

Neck:

Stiffness .... No Yes

Enlarged glands .... No Yes

Respiratory:

Asthma or Wheezing .... No Yes

Difficulty breathing .... No Yes

Any trouble with lungs .... No Yes

Pleurisy or Pneumonia .... No Yes

Cough up Blood (ever) .... No Yes

Cardiovascular:

Chest pain, pressure, or tightness .... No Yes

Shortness of breath with walking or lying down .... No Yes

Difficulty walking two blocks .... No Yes

Palpitations .... No Yes

Swelling of hands, feet or ankles .... No Yes

Awakening in the nights smothering .... No Yes

Heart murmur .... No Yes

Gastrointestinal:

Vomiting blood or food .... No Yes

Gallbladder disease .... No Yes

Change in appetite .... No Yes

Hepatitis/Jaundice .... No Yes

Painful bowel movements .... No Yes

Bleeding with bowel movements .... No Yes

Black stools .... No Yes

Hemorrhoids or piles .... No Yes

Recent change in bowel habits .... No Yes

Frequent diarrhea .... No Yes

Heartburn or indigestion .... No Yes

Cramping or pain in the abdomen .... No Yes

Does food stick in throat .... No Yes

Genitourinary

Loss of urine .... No Yes

Blood in urine .... No Yes

Frequent urination .... No Yes

Burning of painful .... No Yes

Night time urinating .... No Yes

Kidney trouble .... No Yes

Problem stopping/starting flow of urine .... No Yes

Testicular mass .... No Yes

Testicular pain .... No Yes

Prostate problem .... No Yes

Gynecological

First day of last period __________

Age periods started __________

How long do periods last? __________ Days

Frequency of periods: every __________ Days

Pain with periods .... No Yes

Number of pregnancies __________

Number of miscarriages __________

Date of last cancer smear and results __________

Breast Lump .... No Yes

Abnormal Vaginal Discharge .... No Yes

Breast Discharge .... No Yes

Pain with Intercourse .... No Yes

Skin change of Breast .... No Yes

Nipple retraction .... No Yes

Locomotor-Musculoskeletal:

Stiffness or pain in joints (✓ all that apply)

☐ Finger ☐ Hands ☐ Wrist ☐ Elbows ☐ Shoulders ☐ Neck ☐ Back

☐ Hip ☐ Knee ☐ Toes ☐ Foot ☐ Temporomandibular Joint

Weakness of muscles or joints .... No Yes

Any difficulty in walking .... No Yes

Any pain in calves or buttocks on walking relieved by rest .... No Yes

Neuro-Psychiatric:

☐ Transient blindness ☐ Tremor ☐ Numbness in fingers ☐ Weakness

Have you ever had counselling for your mental health? .... No Yes

Have you been advised to see a psychiatrist? .... No Yes

Do you ever have, or have had, fainting spells? .... No Yes

Convulsions .... No Yes

Paralysis .... No Yes

Problem with coordination .... No Yes

Hematologic:

Are you slow to heal after cuts? .... No Yes

Anemia .... No Yes

Phlebitis or Blood Clots in veins .... No Yes

Have you had difficulty with bleeding excessively after tooth extraction or surgery? .... No Yes

Have you had abnormal bruising or bleeding? .... No Yes

Endocrine

Hormone therapy .... No Yes

Any change in hat or glove size .... No Yes

Any change in hair growth .... No Yes

Have you become colder than before - or skin become dryer .... No Yes

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Source of information, if other than patient: __________

Signature of person acquiring this information: __________

__________ Doctor __________ Date __________ Signature of Patient