HEALTH QUESTONNAIRE

Name_____ Age_____ Date_____

Address_____ Phone_____

HISTORY OF PAST ILLNESS: Have you had:

Childhood:

Measles ..... No ❑ Yes ❑
Mumps ..... No ❑ Yes ❑
Chickenpox ..... No ❑ Yes ❑
Diabetes ..... No ❑ Yes ❑
Strokes ..... No ❑ Yes ❑
Cancer ..... No ❑ Yes ❑

Rheumatic fever or heart disease ..... No ❑ Yes ❑
Tuberculosis ..... No ❑ Yes ❑
Any Sexually transmitted disease ..... No ❑ Yes ❑
Congenital abnormalities ..... No ❑ Yes ❑
Other serious diseases / conditions: ..... No ❑ Yes ❑
(please list)_____

Adult:

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

Operations:

Have you had any surgeries? If yes, please list: ..... No ❑ Yes ❑
_____
_____

Injuries:

Have you had any broken bones? ..... No ❑ Yes ❑ _____
Have you had any head injuries? ..... No ❑ Yes ❑ _____
Have you ever been knocked unconscious? ..... No ❑ Yes ❑ _____
Have you had a serious auto accident? ..... No ❑ Yes ❑ _____

FAMILY HISTORY:	If Living: Age	Health	If Deceased: Age (at death)	& Cause:	Has any blood relative ever had:		
Father:					Cancer	No ❑	Yes ❑
Mother:					Tuberculosis	No ❑	Yes ❑
Brother / Sister:					Diabetes	No ❑	Yes ❑
					Heart Trouble	No ❑	Yes ❑
					High blood pressure	No ❑	Yes ❑
Husband / Wife:					Stroke	No ❑	Yes ❑
Son / Daughter:					Convulsions	No ❑	Yes ❑
					Suicide	No ❑	Yes ❑
					Insanity	No ❑	Yes ❑
					Bleeding Tendency	No ❑	Yes ❑
					Gout or other arthritis	No ❑	Yes ❑

SOCIAL HISTORY:

Marital Status: Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑
Alcoholic beverages: Never ❑ Rarely ❑ Moderately ❑ Daily ❑ Ever? ❑
Tobacco: Don't smoke ❑ Smoke ❑ Packs per day:_____
*What is your job?*_____

REVIEW OF SYSTEMS:

General:

Recent weight change? ..... No ❑ Yes ❑
Have you been in good health most of your life? No ❑ Yes ❑

Head-Eyes-Ears-Throat:

Double vision ..... No ❑ Yes ❑
Nosebleeds ..... No ❑ Yes ❑
Chronic sinus trouble ..... No ❑ Yes ❑
Dizziness ..... No ❑ Yes ❑
Bleeding gums ..... No ❑ Yes ❑

Respiratory:

A cold ..... No ❑ Yes ❑
Spitting/coughing up blood ..... No ❑ Yes ❑
Chronic cough ..... No ❑ Yes ❑
Asthma / wheezing ..... No ❑ Yes ❑
Difficulty breathing ..... No ❑ Yes ❑
Pleurisy or pneumonia ..... No ❑ Yes ❑

Cardiovascular:

Chest pain / angina pectoris ..... No ❑ Yes ❑
Shortness of breath when walking/ lying down ..... No ❑ Yes ❑
Heart trouble or heart attacks ..... No ❑ Yes ❑
High blood pressure ..... No ❑ Yes ❑
Swelling of hands, feet or ankles ..... No ❑ Yes ❑
Heart murmur ..... No ❑ Yes ❑

Please complete both sides of this form (Turn over)

Gastrointestinal:

Peptic ulcer (stomach or duodenal) No ❑ Yes ❑
Vomiting blood or food No ❑ Yes ❑
Gallbladder disease / gallstones No ❑ Yes ❑
Liver trouble No ❑ Yes ❑
Hepatitis No ❑ Yes ❑
Pain or bleeding with bowel movements No ❑ Yes ❑
Hemorrhoids or piles No ❑ Yes ❑
Any change in bowel habits No ❑ Yes ❑
Diarrhea No ❑ Yes ❑
Heartburn / indigestion No ❑ Yes ❑
Cramping or pain in the abdomen No ❑ Yes ❑

Genitourinary:

Loss of urine No ❑ Yes ❑
Frequent urination No ❑ Yes ❑
Night time urination No ❑ Yes ❑
Burning or pain with urination No ❑ Yes ❑
Blood in urine No ❑ Yes ❑
Kidney trouble No ❑ Yes ❑
Kidney stones No ❑ Yes ❑

Gynecological:

Age menstrual periods started: _____
How long do periods last?(days) _____
Number of pregnancies: _____
Number of miscarriages: _____
Date of last Pap smear & results: _____
Frequency of periods, every _____ days.
Date of first day of last period: _____
Any pain with your periods? No ❑ Yes ❑
Number of children: _____

Musculoskeletal

Stiffness No ❑ Yes ❑
Weakness in muscles or joints No ❑ Yes ❑
Pain in joints No ❑ Yes ❑
Back pain No ❑ Yes ❑
Muscle cramping No ❑ Yes ❑
Muscle spasm No ❑ Yes ❑

Hematological:

Are you slow to heal after cuts? No ❑ Yes ❑
Any blood disease No ❑ Yes ❑
Anemia No ❑ Yes ❑
Phlebitis No ❑ Yes ❑
Abnormal bleeding or bruising? No ❑ Yes ❑

Endocrine:

Thyroid disease No ❑ Yes ❑
Hormone therapy No ❑ Yes ❑
Any change in hair growth No ❑ Yes ❑
Intolerance to heat or cold No ❑ Yes ❑
Highly emotional No ❑ Yes ❑
Easy to gain or lose weight No ❑ Yes ❑
Hair coarse, falls out easily No ❑ Yes ❑
Reduced sex drive or lacking No ❑ Yes ❑
Dizziness No ❑ Yes ❑
Hot flashes No ❑ Yes ❑

Allergies and Sensitivities:

Please list any drug or food allergies, or any sensitivities:

_____

Height: _____

Weight: _____

Please list any drugs or medications currently taken (including any over the counter medications, birth control pills, etc.):

_____

Please list any vitamins, nutritional supplements, herbs or herbal formulas currently taken:

_____

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

_____ _____ _____

Doctor Date Signature of patient