HEALTH QUESTIONNAIRE

Patient Name: _____

DOB: _____ SS: _____

Please indicate each of your chronic medical problems by marking the appropriate box below:

□ High Blood Pressure	□ Asthma	Please list any other medical problems:
□ Heart Disease	□ Emphysema/Lung Disease	
□ Diabetes	□ Kidney Problems	
□ Stroke	□ Anemia	
□ Cancer	□ High Cholesterol	
□ Thyroid	□ Glaucoma	

Please list all medications that you are now taking, strength (in milligrams) and how often. Include non-prescription medications, vitamins and herbal supplements.

Are you allergic to any medications? □Yes □ No If yes, please list them and the reaction they cause.

SOCIAL HISTORY

Tobacco _____ per / day Number of years _____ Year Quit _____

Alcohol _____ drinks / week Caffeine_____ cups / day Street Drugs _____

Low fat diet □Yes □ No Exercise _____ times / week _____ minutes / session

Water _____ cups / day Marital Status _____ # of Children _____

Occupation _____ Do you have a living will? □Yes □ No

Family History

If any blood relative has suffered from the following conditions, check the box and indicate which relative.

□ Heart Disease	□ Stroke	□ Asthma	□ Father
□ Diabetes	□ High Blood Pressure	□ Emphysema/Lung Disease	□ Mother
□ Thyroid	□ High Cholesterol	□ Cancer	□ Siblings

Patient Name:_____

Please list any surgeries/hospitalizations (including this year):

Are you under the care of any other doctor for any medical problems?_____

Year of last: **Tetanus Shot** _____ **Flu Shot** _____ **Pneumonia Vaccine** _____

WOMEN only: Date of first day of last menstrual period: ___/ ___/ ___ Contraception Type _____

Number of: Pregnancies_____ Live Births _____ Miscarriages_____ Abortions _____

Date of last: PAP _____ (Abnormal? _____) Mammogram _____ (Abnormal?_____)

Date of last: Osteoporosis Scan _____ Flushing/Menopausal Symptoms □Yes □ No

MEN only: Date of last: Prostate Exam _____ Last PSA (Prostate Blood Test) _____

Procedures (list year)

Sigmoidoscopy	Colonoscopy	Stress Test
EKG	Cholesterol (normal Y/N)	Sugar (normal Y/N)

Please place a checkmark next to any symptoms that you are currently having and indicate the year if the symptoms occurred in the past.

GENERAL	□ Fever	□ Night Sweats	□ Unexplained Weight Loss / Gain □ Fatigue
SKIN	□ Rashes	□ Cancers	□ Change in Hair, Skin or Nails
EYES	□ Glasses	□ Contact Lenses	□ Pain □ Changing Vision □ Discharge
EAR NOSE THROAT	□ Ear Pain □ Sore Throat	□ Change in Hearing □ Change in Voice	□ Persistent Runny Nose □ Sinus Trouble
HEART	□ Chest Pain	□ Swelling in Ankles	□ Palpitations o Heart Murmur
LUNGS	□ Cough	□ Short of Breath	□ Wheeze
GASTRO-INTESTINAL	□ Nausea □ Ulcers	□ Blood in Stool □ Heartburn	□ Change in Bowel Movements
GENITO-URINARY	□ Blood in Urine **Women:** **Men:**	□ Painful or Frequent Urination □ Sexually Transmitted Disease □ Vaginal Discharge □ Testicular Pain □ Penile Discharge	 □ Change in Menstrual Cycle or Sexual Function □ Decreased Urinary Stream □ Change in Sexual Function
ORTHOPEDIC	□ Painful Joints	□ Muscle Weakness	
NEURO/PSYCH	□ Seizures	□ Tremor	□ Paralysis □ Frequent Headaches
	□ Depression	□ Anxiety	
ALLERGY	□ Hives	□ Hay Fever	
CIRCULATION	□ Leg Swelling	□ Blood Clots	

_____ _____ _____ _____

Patient Signature Date Clinician Signature Date