

Health Questionnaire

Name: _____ Date: _____ Date of birth: _____

Chief Complaint: _____

Brief History of Problem: _____

Surgical History: _____

Past Medical History: (Please check if applicable)

High Blood Pressure Diabetes Stroke Heart Problems
 Lung Problems Glaucoma Cancer Anemia
 Liver disease Blood Clots Epilepsy
 Gastrointestinal Gynecological Problems

Other: _____

Habits Alcohol _____ #drinks/week Cigarettes: _____ #cig/day _____ #years _____ year quit

Other tobacco usage: _____ Current frequency: _____

Caffeine _____ #cups/day Recreational Drugs _____

Women only:

Date of last PAP test _____ Normal? _____ Abnormal? _____

Date of last mammogram _____ Normal? _____ Abnormal? _____

Date of last period (1st day) _____ Menopausal symptoms? _____

Irregular periods? _____ Menstrual pain? _____

Pre-menstrual complaints?: _____

History of pregnancies: _____

Family History

High Blood Pressure Diabetes Stroke Heart Problems
 Lung Problems Glaucoma Cancer Anemia
 Liver disease Blood Clots Epilepsy Osteoporosis

Other: _____

Allergies: _____

(continued next page)

Current Medications:

Medication	Dosage	Action

Review of Current/Recent Symptoms: (check all those that are applicable)

- General:** ___ Fever ___ Chills ___ Weight Loss ___ Weakness
- Skin:** ___ Rash ___ Itching
- Hematopoietic:** ___ Bruising ___ Bleeding ___ Anemia
- HEENT:** ___ Vision change ___ Double vision ___ Glaucoma ___ Hearing problems
 ___ Vertigo
- Respiratory:** ___ Cough ___ Coughing Blood ___ Shortness of Breath
 ___ Infections
- Cardiovascular:** ___ Chest Pain ___ Murmurs ___ Pain in legs with walking
 ___ Swelling in the legs
- Gastro-Intestinal** ___ Constipation ___ Diarrhea ___ Bleeding ___ Hemorrhoids
 ___ Indigestion ___ Hepatitis
- Genito-Urinary** ___ Burning ___ Bleeding Leaking (incontinence) ___ Flank pain
 ___ Loss of erections
- Muscle-skeletal:** ___ Joint pain ___ Weakness ___ Back pain ___ Cramps
- Neurologic:** ___ Headache ___ Dizziness ___ Seizures ___ Blackouts
 ___ Depression ___ Sleeping problems

Other: _____

Other Comments:

_____ Signature

_____ Date