HEALTH QUESTIONNAIRE

THIS FORM IS TO HELP YOUR DOCTOR PROVIDE YOU BETTER HEALTH CARE.
IT IS COMPLETELY CONFIDENTIAL AND WILL BE A PART OF YOUR MEDICAL RECORD.

Name_____**Age**_____ **Date** _____

Address _____**Phone** _____

Please answer all questions. Circle YES or NO. Write in answers where indicated. Thank You.

PAST HISTORY

Did you ever have an operation? YES NO

If yes, list operation and year performed.

_____
_____
_____
_____

Did you ever have a serious medical illness, which was not a surgical operation? YES NO

If yes, list illness and year of illness.

_____
_____
_____
_____

Have you ever had a serious injury? YES NO

If yes, list injury and date.

_____
_____
_____
_____

Are you allergic to any medications? YES NO

If yes, list the medication and your reaction.

_____
_____
_____
_____
_____

Please list all current medications you are taking.

_____
_____
_____
_____
_____

FAMILY HISTORY

	LIVING		DECEASED	
	Age	Health	Age	Cause
Father				
Mother				
Brothers				
Sisters				

Have any relatives ever had the following?
If so, whom? Yes No

	YES	NO	WHOM
Diabetes			
Heart Trouble			
High Blood Pressure			
Arthritis			
Migraine			
Kidney Disorder			
Goiter			
Cancer			
Tuberculosis			
Stroke			
Epilepsy			
Insanity			

SOCIAL HISTORY- HISTORICAL SOCIAL

What is your occupation?

_____

Occupation History _____

_____
_____

Circle if you are: Single Married Widowed
Separated Divorced

How many children do you have? _____

SOCIAL HISTORY CONT.

How much alcohol do you drink? _____

How much do you smoke? _____

Hobbies _____

_____

_____

Pets _____

_____

_____

Do you have frequent or bad headaches? YES NO

Are headaches common in your family? YES NO

Have you ever seen double? YES NO

Has your eyesight blacked out completely? YES NO

Are you bothered by dizzy spells? YES NO

Have you ever had a convulsion? YES NO

Do you have ringing in your ears? YES NO

Are you hard of hearing? YES NO

Do you have nosebleeds? YES NO

Is you nose frequently stopped up? YES NO

Have you had difficulty swallowing
or speaking? YES NO

Do you have persistent hoarseness? YES NO

Do you have a feeling of a lump in your throat? YES NO

Do you have hay fever or asthma? YES NO

Do you cough frequently? YES NO

Have you ever coughed up blood? YES NO

Did you ever live with anyone who had
tuberculosis? YES NO

Do you have chest pain? YES NO

Does vigorous exertion cause chest discomfort or
pressure? YES NO

Are you short of breath? YES NO

Do you become winded walking up
one flight of stairs? YES NO

Do you sleep on more than one pillow? YES NO

Have you ever awakened short of breath? YES NO

Does your heart thump or skip? YES NO

Do your ankles swell? YES NO

Have you ever been told you had
high blood pressure? YES NO

Have you ever been told you had heart trouble? YES NO

Have you ever had rheumatic fever, growing pains,
or heart trouble? YES NO

Have you ever been told you had emphysema? YES NO

Have you lost or gained more than five pounds
in the past year? YES NO

Is your appetite poor? YES NO

Do you consider yourself overweight? YES NO

Do you consider yourself underweight? YES NO

Do you suffer from indigestion,
heartburn or gas? YES NO

Do you take antacids such as Tums, Rolaids
or baking soda? YES NO

Are you often sick to your stomach? YES NO

Do you have frequent vomiting spells? YES NO

Have you ever-vomited blood? YES NO

Have you ever had an ulcer, gallbladder disease, hepatitis,
colitis or jaundice? YES NO

Have you ever had severe abdominal pain? YES NO

Have you had any recent change in your
bowel movements? YES NO

Do you have loose bowel movements or
constipation? YES NO

Do you have hemorrhoids (piles) YES NO

Have you ever had blood in your
bowel movements? YES NO

Have you ever had black bowel movements? YES NO

Were you ever treated for “bad blood”
(venereal disease)? YES NO

Has a doctor ever said you had a hernia rupture? YES NO

Have you ever passed blood while urinating? YES NO

Do you have trouble starting your stream? YES NO

Do you get up at night to urinate? YES NO

Do you urinate frequently during the daytime? YES NO

Have you had severe burning when you urinate? YES NO

Do you lose control of your bladder? YES NO

Have you ever had a kidney stone or
kidney infection? YES NO

Do you have loss of sexual interest? YES NO

Do you have loss of sexual ability? YES NO

Have you ever had arthritis or rheumatism? YES NO
Are your joints ever swollen or painful? YES NO
Have you ever had sugar in your urine or a high blood sugar? YES NO
Do you have diabetes in your family? YES NO
Do you feel thirsty? YES NO
Have you ever had boils or other skin infections? YES NO
Do you become weak if you do not eat? YES NO
If yes, will it occur between ordinarily paced meals? YES NO
Do you frequently have weak, shaky spells, which are relieved by eating? YES NO
If yes, will this occur only if a regular meal is missed? YES NO
Have you ever taken thyroid hormones? YES NO
Have you ever had a goiter (thyroid enlargement)? YES NO
Do you have bleeding gums? YES NO
Do you bruise easily? YES NO
Have you ever been anemic? YES NO
Have you ever had a blood transfusion? YES NO
Do you have lumps in your neck, under your arms, or in your groin? YES NO
Are you considered a sickly person? YES NO
Do you have difficulty falling asleep or staying asleep? YES NO
Do you awaken tired in the morning? YES NO
Do you often have spells of complete exhaustion? YES NO
Does work tire you out completely? YES NO
Do you push or drive yourself most of the time? YES NO
Does worrying get you down? YES NO
Are you considered a nervous person? YES NO
Did you ever have nervous breakdown? YES NO
Did anyone in your family ever have a nervous breakdown? YES NO
Are your feelings easily hurt? YES NO
Do people misunderstand you? YES NO
Are you easily upset or irritated? YES NO
Do you often get into a violent rage? YES NO
Do you often shake or tremble? YES NO
Are you constantly keyed up or jittery? YES NO
Do frightening thoughts keep coming back in your mind? YES NO
Do you often cry? YES NO
Do you feel unhappy and depressed? YES NO
Are you always miserable and blue? YES NO
Does life look entirely hopeless? YES NO
Do you often wish you were dead and away form it all? YES NO

Please list dates you have had the following…

Rectal Exam _____

_____

Pelvic Exam _____

_____

Pap Smear _____

_____

Mammogram _____

_____

Cardiac Lipid Profile _____

_____

Immunizations _____

_____

_____

THIS SECTION FOR WOMEN PATIENTS ONLY

Are your menses irregular? YES NO
Do you have severe cramps with your menses? YES NO
Do you have hot flashes? YES NO
Are you bothered by an irritating vaginal discharge? YES NO
Do you have discharge from your breasts? YES NO
Have you ever been pregnant? YES NO
Have any of your babies weighed 8 lbs. or more at birth? YES NO