HEALTH QUESTIONNAIRE

TO BE COMPLETED BY PATIENT **PLEASE PRINT**

NAME________________________ **DATE**________________

Reason for Visit________________________

Current Concerns________________________

Drug Allergies________________________

Family History:	Father	Mother	Bro / Sis	Bro / Sis	Bro / Sis	Bro / Sis	Mother's Rel	Father's Rel
Alive/Age								
Deceased/Age								
Alcoholism								
Anemia								
Arthritis								
Asthma								
Bleeds Easily								
Cancer								
Diabetes								
Eczema								
Epilepsy								
Glaucoma								
Hayfever								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Mental Illness								
Migraine								
Psoriasis								
Stroke								

Hospital Admissions: *Indicate the year you were admitted and the reason.* ***Do not include normal pregnancies.***

Year	**Illness or Surgery**	**Year**	**Illness or Surgery**

Medications: *List all medications you are now taking,* ***including over the counter and herbs/supplements.***

Name	Strength	How Often	Name	Strength	How Often

Medical History: *Mark (C) for current problems. Mark (X) and indicate age when you had any of the following symptoms or diseases.*

Main Problems: (1)________________ (2)________________ (3)________________

___Decreased Hearing
___Ringing in Ear
___Ear Infections-Frequent
___Dizzy Spells ___Glaucoma
___Failing Vision ___Cataracts
___Doubled or Blurred Vision
___Eye Infections-Frequent
___Nose Bleeds ___Sinusitis
___Sore Throat-Frequent
___Hayfever ___Allergies
___Hoarseness-Prolonged
___Pneumonia / Pleurisy
___Bronchitis / Chronic Cough
___Asthma / Wheezing
Shortness of Breath
___On exertion ___Lying flat
___Chest pain
___High Blood Pressure
___Heart Murmur ___Palpitations
___Irregular Pulse ___Fainting
___Swollen Ankles

___Leg Pain When Walking
___Varicose Veins ___Phlebitis
___Loss of appetite-Recent
___Difficulty Swallowing
___Indigestion or Heartburn
___Persistent Nausea/Vomiting
___Peptic Ulcers
___Abdominal Pain-Chronic
___Change in bowel habits
___Diarrhea ___Constipation
___Diverticulosis ___Blood in Stools
___Hemorrhoids ___Hernia
___Gallbladder trouble
___Jaundice ___Hepatitis
___Urine infections-Frequent
___Painful Urination
___Blood in Urine
___Control of Urination
___Decreased Force in Urination
___Kidney Stones
___Venereal Disease

___Chronic Fatigue
___Weight Loss-Recent
___Anemia ___Bruise Easily
___Cancer
___Diabetes ___Thyroid Disease
___Convulsions/Seizures
___Stroke
___Tremor / Hands Shaking
___Numbness / Tingling Sensation
___Headaches-Frequent
___Arthritis/Rheumatoid ___Gout
___Back pain-Recurrent
___Bone fracture / Joint injury
___Foot pain ___Cold numb feet
___Rashes ___Hives
___Psoriasis ___Eczema
___Sleeping difficulty
___Nervousness ___Depression
___Memory Loss ___Mental Illness
___Moodiness ___Phobias
___Recent Hair Loss

___Herpes ___Chlamydia
___Chicken Pox ___Polio ___Mumps
___Measles ___German Measles
___Rheumatic ___Scarlet Fever ___TB
___Alcohol ___oz per week
___Smoking _____cigarettes per day ____# years
___Coffee/Tea _____cups per day

IMMUNIZATION Year of Last Injection
______Pneumonia ______Flu ______Tetanus
______Diptheria ______Measles ______Mumps
______Rubella ______Polio ______Hepatitis

Females - Date of last PAP________
Date of last Mammogram________
____Age of Menstruation___Reg___ Irreg
____Pain / Cramps with Menstruation
____# of Pregnancies ___# of Live Births
____# of Miscarriages
Birth Control Method________
___Flushing / Menopause

Date of Last TB Test________ Date of Last Chest X-ray________ Date of Last Lab Work________

Reviewed by Physician________________ Date________