



## Health Questionnaire

---

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

**Brief History of Problem:** \_\_\_\_\_

\_\_\_\_\_

**Surgical History:** \_\_\_\_\_

\_\_\_\_\_

**Past Medical History:** (Please check if applicable)

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Anemia
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> 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 (1<sup>st</sup> day) \_\_\_\_\_ Menopausal symptoms? \_\_\_\_\_

Irregular periods? \_\_\_\_\_ Menstrual pain? \_\_\_\_\_

Pre-menstrual complaints?: \_\_\_\_\_

History of pregnancies: \_\_\_\_\_

**Family History**

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Anemia
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> 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