

NAME:

HEALTH QUESTIONNAIRE

REASONS FOR VISIT

FAMILY HISTORY	ALIVE & WELL	DECEASED	CAUSE OF DEATH (AGE)	HIGH BLOOD PRESSURE	HEART DISEASE	EPILEPSY	DIABETES	CANCER	ASTHMA	HAYFEVER	ARTHRITIS	KIDNEY DISEASE	GLAUCOMA	STROKE	MIGRAINE	MENTAL ILLNESS	ALCOHOLISM	BLEEDS EASILY	ANEMIA	PSORIASIS	ECZEMA	OTHER	
FATHER																							
MOTHER																							
BROS/SIS																							
MOTHER'S RELATIVES																							
FATHER'S RELATIVES																							

HOSPITAL ADMISSIONS	INDICATE THE YEAR YOU WERE ADMITTED TO HOSPITAL AND THE REASON. DO NOT INCLUDE NORMAL PREGNANCIES.	MEDICATIONS	NAME	STRENGTH	HOW OFTEN
YEAR	ILLNESS OR OPERATION	LIST ALL MEDICATIONS THAT YOU ARE NOW TAKING INCLUDING OVER THE COUNTER RX.			
		DRUG/FOOD ALLERGIES			

MEDICAL HISTORY Mark (C) for current problems. Check (✓) box and indicate age when you had any of the following symptoms or diseases.

MAIN PROBLEMS (1) _____ (2) _____ (3) _____

- | | | | |
|---|---|--|---|
| <p>Eyes</p> <input type="checkbox"/> Glaucoma <input type="checkbox"/> Failing vision
<input type="checkbox"/> Cataracts <input type="checkbox"/> Eye pain
<input type="checkbox"/> Double or blurred vision
<input type="checkbox"/> Eye infections - frequent
<input type="checkbox"/> Itching eyes <input type="checkbox"/> See halos <p>Ears</p> <input type="checkbox"/> Decreased hearing
<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Ear infections - frequent
<input type="checkbox"/> Dizzy spells <p>Nose-Throat-Mouth</p> <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sinusitis
<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Sore throats - frequent
<input type="checkbox"/> Hoarseness - prolonged
<input type="checkbox"/> Enlarged tonsils
<input type="checkbox"/> Loss of smell <input type="checkbox"/> Running nose
<input type="checkbox"/> Hay fever/Allergies
<input type="checkbox"/> Dental problems
<input type="checkbox"/> Bleeding gums
<input type="checkbox"/> Jaw pain
<input type="checkbox"/> Sore tongue <input type="checkbox"/> Taste changes <p>Respiratory</p> <input type="checkbox"/> Pneumonia/Pleurisy
<input type="checkbox"/> Bronchitis/Chronic Cough
<input type="checkbox"/> Cough w/phlegm or blood
<input type="checkbox"/> Asthma/Wheezing
<input type="checkbox"/> Fever <p>Cardiovascular</p> <input type="checkbox"/> Shortness of breath
<input type="checkbox"/> On Exertion <input type="checkbox"/> Lying Flat
<input type="checkbox"/> Chest pain (angina)
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Heart murmur <input type="checkbox"/> Palpitations
<input type="checkbox"/> Irregular pulse <input type="checkbox"/> Fainting spells
<input type="checkbox"/> Swollen ankles
<input type="checkbox"/> Hardening of arteries | <p><input type="checkbox"/> CHF
 <input type="checkbox"/> Leg pain when walking
 <input type="checkbox"/> Varicose veins <input type="checkbox"/> Phlebitis</p> <p>Digestive</p> <input type="checkbox"/> Loss of appetite - recent
<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Indigestion/Heartburn
<input type="checkbox"/> Persistent nausea/vomiting
<input type="checkbox"/> Peptic ulcers
<input type="checkbox"/> Abdominal pain - chronic
<input type="checkbox"/> Change in bowel habits
#Bowel movements/day _____
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation
<input type="checkbox"/> Diverticulitis <input type="checkbox"/> Blood in stool
<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia
<input type="checkbox"/> Ulcerative colitis
<input type="checkbox"/> Fissures/Fistula
<input type="checkbox"/> Vomiting of blood
<input type="checkbox"/> Colon cancer <p>Urinary</p> <input type="checkbox"/> Urine infections - frequent
<input type="checkbox"/> Painful urination
<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Control of urinations
<input type="checkbox"/> Decreased force in urination
<input type="checkbox"/> Kidney stones <p>Sexual</p> <input type="checkbox"/> Venereal disease
<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Herpes <input type="checkbox"/> Chlamydia <p>Muscular</p> <input type="checkbox"/> Arthritis/Rheumatism
<input type="checkbox"/> Gout
<input type="checkbox"/> TMJ
<input type="checkbox"/> Back pain - recent
<input type="checkbox"/> Bone fracture/Joint injury/Joint pain
<input type="checkbox"/> Foot pain | <p><input type="checkbox"/> Sciatica
 <input type="checkbox"/> Loss of limb</p> <p>Skin</p> <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Acne
<input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema
<input type="checkbox"/> Lumps
<input type="checkbox"/> Recent hair loss
<input type="checkbox"/> Skin cancer <p>Endocrine</p> <input type="checkbox"/> Weight loss - recent
<input type="checkbox"/> Weight gain - recent
<input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily
<input type="checkbox"/> Cold hands & feet
<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chronic fatigue - Adrenal fatigue
<input type="checkbox"/> Gall bladder
<input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <p>Neurological</p> <input type="checkbox"/> Convulsions/Seizures
<input type="checkbox"/> Stroke
<input type="checkbox"/> Tremors/Hand shaking
<input type="checkbox"/> Numbness/Tingling sensations
<input type="checkbox"/> Headaches - frequent <p>Mood</p> <input type="checkbox"/> Sleeping - difficulty # hours sleep _____
<input type="checkbox"/> Nervousness <input type="checkbox"/> Depression
<input type="checkbox"/> Emotional problems <input type="checkbox"/> Mental illness
<input type="checkbox"/> Memory loss <input type="checkbox"/> Moodiness
<input type="checkbox"/> Lack of concentration <input type="checkbox"/> Mood swings
<input type="checkbox"/> Phobias <input type="checkbox"/> Anxiety <p>Viral</p> <input type="checkbox"/> Chicken pox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps
<input type="checkbox"/> Measles <input type="checkbox"/> German measles
<input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Tuberculosis | <p><input type="checkbox"/> Alcohol _____ oz per week
 <input type="checkbox"/> Smoking _____ cig per day _____ # yrs.
 <input type="checkbox"/> Coffee/Tea _____ cups per day
 <input type="checkbox"/> Soda _____ cups per day</p> <div style="border: 1px solid black; padding: 5px;"> <p>IMMUNIZATIONS Year of Last Injection</p> <p>____ Pneumonia ____ Flu ____ Tetanus
 ____ Diphtheria ____ Measles ____ Mumps
 ____ Rubella ____ Polio ____ Hepatitis</p> </div> <p><input type="checkbox"/> Exposure heavy metals/chemicals
 <input type="checkbox"/> Do you have a living will? _____
 Blood type _____
 Sexually active <input type="checkbox"/> Low libido <input type="checkbox"/>
 Method of contraception _____</p> <p>FEMALES - MENSTRUAL HISTORY</p> <p>Age of onset ____ <input type="checkbox"/> Reg <input type="checkbox"/> Irregular
 _____ Days of flow _____ Length of cycle
 <input type="checkbox"/> Pain / Cramps with menstrual flow
 No. of pregnancies ____ No. of live births ____
 No. of miscarriages ____
 Last Pap ____
 Are you pregnant ____
 Last Mammogram ____
 <input type="checkbox"/> Flushing/Menopause
 <input type="checkbox"/> Breast pain <input type="checkbox"/> Vaginal discharge
 <input type="checkbox"/> Sexual abuse
 <input type="checkbox"/> HRT <input type="checkbox"/> PMS
 <input type="checkbox"/> Tenderness in breast
 <input type="checkbox"/> Endometriosis
 <input type="checkbox"/> Fibroids
 <input type="checkbox"/> Cysts</p> |
|---|---|--|---|