Health Questionnaire

To be completed by the patient- please print

Name ______________________________________ Date ____________________________

Date of Birth ___________________ Height____________ Weight _____________________

Drug/Food/Seasonal Allergies____

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Chief Complaints please list in order of importance the present health concerns, symptoms, or problems you are experiencing:

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Hospitalizations/Past Surgical History,

State the year- illness/operation (do not include normal pregnancies)

Year	Illness/Operation

Past Medical History Have you ever had the following (circle yes or no, leave blank if uncertain)

			YEAR				YEAR				YEAR
AIDS or HIV+	Y	N		Glaucoma	Y	N		Pneumonia	Y	N	
Anemia	Y	N		Heart Disease	Y	N		Polio	Y	N	
Arthritis	Y	N		Hemorrhoids	Y	N		Rheumatic Fever	Y	N	
Asthma	Y	N		Hepatitis	Y	N		Scarlet Fever	Y	N	
Back Trouble	Y	N		Hernia	Y	N					
Bladder Infections	Y	N		High B/P	Y	N		Stroke	Y	N	
Bleeding Tendency	Y	N		Hives or eczema	Y	N		Thyroid Disease	Y	N	
Bronchitis	Y	N		High Cholesterol	Y	N		Transfusions	Y	N	
Cancer/Type	Y	N		Kidney Disease	Y	N		Tuberculosis	Y	N	
Chicken Pox	Y	N		Measles	Y	N		Ulcer	Y	N	
Diabetes	Y	N		Migraines	Y	N		Venereal Disease	Y	N	
Diphtheria	Y	N		Mitral Valve	Y	N		Whooping Cough	Y	N	
Epilepsy	Y	N		Mumps	Y	N					

Any other disease, please list in comment section below

Comments: ____

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Family History Has any blood relative had any of the following (M = Maternal, P=Paternal)?

			Relationship	M/P				Relationship	M/P
Allergies	Y	N	____________	____	Epilepsy	Y	N	____________	____
Anemia	Y	N	____________	____	Heart Disease	Y	N	____________	____
Bleeding Tendency	Y	N	____________	____	High Blood Press	Y	N	____________	____
Cancer	Y	N	____________	____	Stroke	Y	N	____________	____
Type of Cancer			____________	____					
Diabetes	Y	N	____________	____	Tuberculosis	Y	N	____________	____

Medications Dosage Times/Day

____
____
____
____
____
____

Social History

Tobacco	Y	N	Amt. Used Currently____ Amt. Used Formerly _____
			Age Started________ Age Stopped________
Alcohol	Y	N	Drinks per week ________________________
Caffeine	Y	N	Cups per day ___________________________
Illegal Drugs	Y	N	Type ___________________________________

Give the year of your last:

Flu Vaccine	______________	Tetanus Shot	____________
Hepatitis Vaccine	______________	TB Test	____________
Pneumonia Shot	______________	Rubella Vaccine	____________
Stool Blood Test	______________	Rectal Exam	____________
Colonoscopy	______________	Eye Exam	____________
Cholesterol Test	______________	PSA	____________

For Women Only

Age at onset of menstrual period _________________________________

Date of last menstrual period _________________________________

Use Birth Control No Yes Type ______________________________

Number of pregnancies _______________ Number of live births ____________

Number of abortions ______________ Number of miscarriages___________

What was the last year of exam:

Breast Exam _______________________ Results ______________________

Mammogram ______________________ Results ______________________

Pap______________________________ Results ______________________

Dexa Scan/Bone Density_____________ Results_______________________