HEALTH QUESTIONNAIRE

NAME ________________________________ AGE ____________ DATE ____________

HISTORY OF PAST ILLNESS/INJURIES (HAVE YOU HAD?):

MEDICAL RECORD # ____________

	YES	NO	UNSURE
MEASLES	❑	❑	❑
MUMPS	❑	❑	❑
CHICKEN POX	❑	❑	❑
DIABETES	❑	❑	❑
STROKES	❑	❑	❑
CANCER	❑	❑	❑
RHEUMATIC FEVER OR HEART DISEASE	❑	❑	❑
TUBERCULOSIS	❑	❑	❑
SEXUALLY TRANSMITTED DISEASE	❑	❑	❑
CONGENITAL ABNORMALITIES	❑	❑	❑
OTHER SERIOUS DISEASES	❑	❑	❑

LIST ____________________

	YES	NO
HAVE YOU EVER BEEN HOSPITALIZED OR BEEN UNDER MEDICAL CARE FOR VERY LONG?	❑	❑

IF YES, FOR WHAT REASON? ____________________

	YES	NO
HAVE YOU HAD ANY HEAD INJURIES?	❑	❑
HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS?	❑	❑

OPERATIONS:

	YES	NO
HAVE YOU HAD ANY SURGERY?	❑	❑

PLEASE DESCRIBE ____________________

FAMILY HISTORY	IF LIVING:		IF DECEASED:		HAS ANY BLOOD RELATIVE EVER HAD?		
	AGE	HEALTH	AGE	CAUSE		YES	NO
FATHER					CANCER		
MOTHER					TUBERCULOSIS		
BROTHER / SISTER					DIABETES		
					HEART TROUBLE		
					HIGH BLOOD PRESSURE		
HUSBAND / WIFE					STROKE		
SON / DAUGHTER					CONVULSIONS		
					SUICIDE OR SEVERE DEPRESSION		
					MENTAL ILLNESS		
					BLEEDING TENDENCY		
					GOUT OR OTHER ARTHRITIS		
					ALCOHOL OR DRUG PROBLEMS		

SOCIAL HISTORY: ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

	YES	NO
DO YOU LIVE ALONE?	❑	❑
DO YOU HAVE DEPENDENTS AT HOME?	❑	❑
DO YOU EXERCISE REGULARLY?	❑	❑
DO YOU SMOKE?	❑	❑

HOW MUCH? ____________________

	YES	NO
HAVE YOU ***EVER*** SMOKED?	❑	❑
HAVE YOU EVER FELT YOU SHOULD CUT DOWN ON YOUR DRINKING?	❑	❑

SYSTEMIC REVIEW (DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?):

GENERAL:	YES	NO
RECENT WEIGHT CHANGE?	❑	❑
SKIN:	YES	NO
JAUNDICE?	❑	❑
HIVES, ECZEMA OR RASH?	❑	❑
FREQUENT INFECTION OR BOILS?	❑	❑
ABNORMAL PIGMENTATION?	❑	❑
HEAD-EYES-EARS-NOSE-THROAT:	YES	NO
EYE DISEASE OR INJURY	❑	❑
DO YOU WEAR GLASSES/CONTACTS?	❑	❑
DOUBLE VISION	❑	❑
HEADACHES	❑	❑
GLAUCOMA	❑	❑
HEAD-EYES-NOSE-THROAT: (cont´d)	YES	NO
SNEEZING OR RUNNY NOSE	❑	❑
NOSE BLEEDS	❑	❑
CHRONIC SINUS TROUBLE	❑	❑
EAR DISEASE	❑	❑
IMPAIRED HEARING	❑	❑
ITCHING EYES OR NOSE	❑	❑
TRANSIENT EPISODES OR UNCONSCIOUSNESS	❑	❑
DIZZINESS	❑	❑
NECK:	YES	NO
STIFFNESS	❑	❑
THYROID TROUBLE	❑	❑
ENLARGED GLANDS	❑	❑

(OVER PLEASE)

NAME ____________________ DATE __________

SYSTEMIC REVIEW (Cont'd):

RESPIRATORY:	YES	NO
SPITTING UP BLOOD?	❑	❑
CHRONIC OR FREQUENT COUGH	❑	❑
ASTHMA/WHEEZING OR DIFFICULTY BREATHING	❑	❑
PLEURISY OR PNEUMONIA	❑	❑

CARDIOVASCULAR:	YES	NO
CHEST PAIN/ANGINA PECTORIS OR HEART ATTACK		
SHORTNESS OF BREATH WALKING OR LYING DOWN	❑	❑
HIGH BLOOD PRESSURE	❑	❑
SWELLING OF HANDS, FEET OR ANKLES	❑	❑
AWAKENING IN THE NIGHT SMOTHERING	❑	❑
HEART MURMUR/PALPITATIONS	❑	❑

GASTROINTESTINAL:	YES	NO
PEPTIC ULCER (STOMACH/DUODENAL)	❑	❑
HEARTBURN/INDIGESTION	❑	❑
VOMITING BLOOD OR FOOD	❑	❑
GALLBLADDER DISEASE	❑	❑
LIVER TROUBLE/HEPATITIS	❑	❑
PAINFUL/BLOODY BOWEL MOVEMENTS	❑	❑
HEMORRHOIDS/PILES OR BLACK STOOLS	❑	❑
CHANGE IN BOWEL HABITS (DIARRHEA, ETC.)	❑	❑
CRAMPING OR PAIN IN THE ABDOMEN	❑	❑
DOES FOOD STICK IN THROAT?	❑	❑

GYNECOLOGICAL (FEMALE ONLY):

AGE PERIODS STARTED ____________________

HOW LONG PERIODS LAST ____________________ DAYS

FREQUENCY OF PERIODS ____________________ DAYS

NUMBER OF PREGNANCIES ____________________

NUMBER OF MISCARRIAGES/ABORTIONS ____________________

DATE OF LAST PAP SMEAR __________ RESULTS __________

DATE OF LAST MAMMOGRAM __________ RESULTS __________

GENITOURINARY:	YES	NO
LOSS OF URINE	❑	❑
FREQUENT URINATION (DAY OR NIGHT)	❑	❑
BURNING OR PAINFUL URINATION	❑	❑
BLOOD IN URINE	❑	❑
KIDNEY TROUBLE (STONES, ETC.)	❑	❑

LOCOMOTOR-MUSCULOSKELETAL:	YES	NO
VARICOSE VEINS	❑	❑
ANY DIFFICULTY IN WALKING	❑	❑
ANY PAIN IN CALVES OR BUTTOCKS ON WALKING, RELIEVED BY REST	❑	❑

NEUROLOGIC:	YES	NO
HAVE YOU HAD FAINTING SPELLS?	❑	❑
CONVULSIONS	❑	❑
PARALYSIS	❑	❑

HEMATOLOGIC:	YES	NO
ARE YOU SLOW TO HEAL AFTER CUTS?	❑	❑
BLOOD DISEASE	❑	❑
ANEMIA	❑	❑
PHLEBITIS	❑	❑
EXCESSIVE BLEEDING OR ABNORMAL BRUISING?	❑	❑

ENDOCRINE:	YES	NO
THYROID DISEASE	❑	❑
HORMONE THERAPY	❑	❑
ANY CHANGE IN HAT OR GLOVE SIZE	❑	❑
ANY CHANGE IN HAIR GROWTH	❑	❑
HAVE YOU BECOME COLDER THAN BEFORE, OR SKIN BECOME DRYER?	❑	❑

PSYCHIATRY:	YES	NO
HAVE YOU EVER BEEN ADVISED TO SEEK OR HAVE YOU SOUGHT TREATMENT FOR:		
DEPRESSION	❑	❑
ANXIETY AND/OR PANIC	❑	❑
SEVERE STRESS	❑	❑
ALCOHOL AND/OR DRUG ABUSE	❑	❑

PLEASE LIST ALL KNOWN ALLERGIES (DRUGS, FOOD, ANIMALS, ETC.):

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____________________ ____________________

SIGNATURE OF PATIENT: ____________________ **DATE** __________

QUESTIONNAIRE REVIEWED BY: ____________________ **DATE** __________

(MEDICAL PROVIDER)