HEALTH QUESTIONNAIRE

NAME _____ AGE _____ DATE _____

HISTORY OF PAST ILLNESS/INJURIES (HAVE YOU HAD? CHECK ALL THAT APPLY):

Measles/Mumps.....☐ Seizure……☐ Peptic Ulcer……..☐ Skin Disorder…..☐ Osteoporosis……..☐
Allergies……...☐ Heart Disease……☐ Kidney Disease……☐ Arthritis……☐ Migraines……..☐
Chicken Pox……☐ Hypertension……☐ Diabetes……☐ Back Pain……☐ Anxiety……☐
Polio…… ..☐ Tuberculosis……..☐ Thyroid Disease……..☐ Epilepsy……☐
Depression……..☐
Rheumatic Fever..☐ Pneumonia……☐ Venereal Disease…...☐ Glaucoma……☐ Eating Disorder……..☐
Acid Reflux ..……☐ Asthma……☐ Anemia ……..☐ HighCholesterol☐ Alcoholism……☐
Cancer…… ..☐ Hepatitis……☐ Phlebitis/Blood Clot…..☐ Joint Disorder…☐ Substance Abuse……☐
Stroke…… ..☐ Liver Disease…...……☐ Gout……☐ Lung Disease…☐ ☐ Other_____

Past Surgical History: Any other significant illnesses, injuries, or hospitalizations:

Year _____Illness _____ Year_____ Surgery_____
Year _____Illness _____ Year_____ Surgery_____
Year _____Illness_____ Year_____ Surgery_____

FAMILY HISTORY	IF LIVING:		IF DECEASED:		HAS ANY BLOOD RELATIVE EVER HAD:		
	AGE	HEALTH	AGE	CAUSE		YES	NO
FATHER					CANCER -TYPE:		
MOTHER					TUBERCULOSIS		
BROTHER					DIABETES		
SISTER					HEART TROUBLE		
					HIGH BLOOD PRESSURE		
					STROKE		
					CONVULSIONS		
HUSBAND / WIFE					SUICIDE OR SEVERE DEPRESSION		
SON / DAUGHTER					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 : _____TIMES A WEEK..... ☐ ☐
DO YOU SMOKE :……CURRENT…☐…… FORMER…☐…… NEVER ☐
IF YES, HOW MUCH_____ HOW MANY YEARS_____

DO YOU DRINK……☐ ☐
HOW OFTEN DO YOU DRINK: _____TIMES PER_____

DO YOU WEAR GLASSES/CONTACTS……..YES ☐ NO ☐
MONTHS_____

	YES	NO
HAVE PEOPLE EVER ANNOYED YOU BY CRITICIZING YOUR DRINKING……	☐	☐

ARE YOU CURRENTLY EMPLOYED:
☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED
WHAT IS YOUR OCCUPATION?
_____
___
YEARS OF EDUCATION COMPLETED:
_____
HOW MUCH *WORK TIME* HAVE YOU LOST DUE TO YOUR HEALTH WITHIN THE PAST 6

MEDICATIONS: ARE YOU TAKING ANY MEDICATIONS or VITAMINS **YES** ☐ **NO** ☐
PLEASE LIST ALL MEDICATIONS INCLUDING SUPPLEMENTS

_____ _____ _____ _____
_____ _____ _____ _____

cont'd please see back--→

Review of Systems

GENERAL
- □ CHILLS
- □ DIZZINESS
- □ FAINTING
- □ FEVER
- □ HAIR LOSS
- □ HAIR GROWTH (EXCESS)
- □ NIGHT SWEATS
- □ SLEEPING PROBLEMS
- □ THIRST (EXCESS)
- □ WEIGHT GAIN
- □ WEIGHT LOSS

MENTAL HEALTH
- □ ANXIETY
- □ DEPRESSION
- □ LOSS OF INTEREST
- □ FEELING HOPELESS
- □ HEARING VOICES
- □ MARITAL PROBLEMS
- □ PANIC ATTACK
- □ TROUBLE CONCENTRATING
- □ SUICIDE (THOUGHT/ATTEMPS)

SKIN
- □ ACNE
- □ BRUISE EASILY
- □ CHANGES IN MOLES
- □ CHILLS
- □ DRY/ SENSITIVE SKIN
- □ ECZEMA
- □ HIVES
- □ RASH
- □ SCARS
- □ SORES THAT WON'T HEAL

GASTROINTESTINAL
- □ APPETITE GAIN
- □ APPETITE LOSS
- □ BLOATING
- □ BOWEL CHANGES
- □ CONSTIPATION
- □ DIARRHEA
- □ GAS
- □ HEMORRHOIDS
- □ INDIGESTION
- □ INTESTINAL DISORDER
- □ LACTOSE INTOLERANCE
- □ NAUSEA
- □ RECTAL BLEEDING
- □ STOMACH PAIN
- □ VOMITING
- □ VOMITING BLOOD

GENITOURINARY
- □ BLOOD IN URINE
- □ LACK OF BLADDER CONTROL
- □ FREQUENT URINATION
- □ PAINFUL URINATION

RESPIRATORY
- □ COUGHING
- □ COUGHING BLOOD
- □ SHORTNESS OF BREATH
- □ WHEEZING

CARDIOVASCULAR
- □ CHEST PAINS
- □ IRREGULAR HEATH BEAT
- □ RAPID HEATH BEAT
- □ SWELLING OF ANKLES
- □ VARICOSE VEINS
- □ CIRCULATION PROBLEMS

NEUROLOGICAL
- □ COORDINATION PROBLEM
- □ CONVULSION
- □ DIFFICULTY WALKING
- □ LEARNING DISABILITY
- □ LIGHT-HEADEDNESS
- □ MEMORY LOSS
- □ NUMBNESS
- □ TINGLING
- □ SEIZURE
- □ SPEECH PROBLEMS
- □ TREMORS
- □ PARALYSIS

WOMEN ONLY
- □ ANORMAL PAP SMEAR
- □ BLEEDING B/W PERIODS
- □ BREAST LUMP
- □ EXTREME MENSTRUAL PAIN
- □ HOT FLASHES
- □ NIPPLE DISCHARGE
- □ PAINFUL INTERCOURSE
- □ VAGINAL DISCHARGE
- □ **AGE PERIOD STARTED**

_____

- □ # OF PREGNANCIES

_____

- □ # MISCARRIAGES/ ABORTION

_____

- □ **LAST PAP SMEAR**

MM/YY_____

- □ **LAST MAMMOGRAM**

MM/YY_____

EAR/NOSE/THROAT
- □ BLEEDING GUMS
- □ BLURRED VISION
- □ CROSSED EYES
- □ DIFFICULTY SWALLOWING
- □ DOUBLE VISION
- □ EAR ACHE
- □ EAR DISCHARGE
- □ HAY FEVER
- □ HOARSENESS
- □ HEARING LOSS
- □ NOSE-BLEEDS
- □ PERSISTENT COUGH
- □ RECURRING SORE THROAT
- □ RINGING IN EARS
- □ SINUS PROBLEM
- □ VISION HALOS

MUSCULOSKELETAL
- □ BACK PAIN
- □ CARPEL TUNNEL SYNDROME
- □ JOINT PAIN
- □ JOINT SWELLING
- □ NECK PAIN
- □ SHOULDER PAIN

MEN ONLY
- □ ERECTILE DIFFICULTIES
- □ TESTICULAR LUMP
- □ PENILE DISCHARGE
- □ SORE ON PENIS

PLEASE LIST ALL KNOWN ALLERGIES (DRUGS, FOOD, ANIMALS, ETC): ☐ NONE

☐ ASPIRIN ☐ CODEIN ☐ IODINE ☐ SOY ☐ DAIRY

☐ PENICILLIN ☐ IBUROFEN ☐ LATEX ☐ EGG ☐ GLUTEN

☐ SULFA ☐ AUGMENTIN ☐ ANTIBIOTIC ☐ SHELLFISH ☐ OTHER:_____

PATIENT DEMOGRAPHIC

- □ .....Asian
- □ .....Caucasian
- □ .....Hispanic
- □ .....Indian
- □ .....Black/ African American
- □ .....Other: _____

ETHNICITY:
- □ OTHER
- □ Hispanic
- □ Latino
- □ Unknown
- □ Decline

LANGUAGE:
- □ English
- □ Farsi
- □ Spanish
- □ Other: _____

SIGNATURE OF PATIENT: _____ **DATE**_____

QUESTIONNAIRE REVIEWED BY: _____ **DATE**_____

(MEDICAL PROVIDER)