TO BE COMPLETED BY PATIENT - PLEASE PRINT

HEALTH QUESTIONNAIRE

REASON FOR VISIT	
CURRENT CONCERNS	
DRUG ALLERGIES	

FAMILY HISTORY:

For each member of your family, follow the grey or white line across the page and check the boxes for:
1. Their present state of health 2. Any illnesses they have had

(Note: Except for spouse, Family refers to blood or natural relatives.)

PRINT NAMES BELOW:

	Good Health	Poor Health	Deceased → Write in age and cause of death. Include fatal accidents and suicides.	Allergies or asthma	Anemia	Blood Clotting problems	Diabetes	Cancer or tumor	Epilepsy	Glaucoma	Genetic Disease	Alcoholism	Kidney or bladder trouble	Stomach/duodenal ulcer	Nervous breakdown	Rheumatism or arthritis	High blood pressure	Heart trouble	Gout
Father																			
Mother:																			
Brothers/Sisters:																			
Spouse:																			
Child:																			
Child:																			
Child:																			
Child:																			
Paternal relatives (in each box, write how many affected with) ➢																			
Maternal relatives (in each box, write how many affected with) ➢																			
Begin YOUR HEALTH HISTORY here. Have you had ➢																			

MEDICATIONS

LIST ALL MEDICATIONS THAT YOU ARE NOW TAKING. INCLUDE OVER THE COUNTER RX.

NAME	STRENGTH	HOW OFTEN

VACCINE	Year of Last	TEST/EXAM	Year of Last
Tetanus / Td		Rectal/Stool	
Influenza (FLU)		Cholesterol	
Phenumonia		Physical Exam	
Hepatitis		Blood Count	
Hepatitis		Blood Sugar	

MEDICAL HISTORY

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

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

- ❑ Decreased hearing
- ❑ Ringing in ear
- ❑ Ear infections-frequent
- ❑ Dizzy spells ❑ Glaucoma
- ❑ Failing vision ❑ Cataracts
- ❑ Double or blurred vision
- ❑ Eye infections - frequent
- ❑ Nose bleeds ❑ Sinusitis
- ❑ Sore throats - frequent
- ❑ Hayfever ❑ Allergies
- ❑ Hoarseness - prolonged
- ❑ Pneumonia/Pleurisy
- ❑ Bronchitis/Chronic cough
- ❑ Asthma/Wheezing

Shortness of breath:
- ❑ On exertion ❑ Lying flat
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Heart Murmur ❑ Palpitations
- ❑ Irregular Pulse ❑ Fainting Spells
- ❑ Swollen Ankles

- ❑ Leg pain when walking
- ❑ Varicose veins ❑ Phlebitis
- ❑ Loss of appetite - recent
- ❑ Difficulty swallowing
- ❑ Indigestion of heart burn
- ❑ Persistent Nausea/Vomiting
- ❑ Peptic ulcers
- ❑ Abdominal Pain - chronic
- ❑ Change in bowel habits
- ❑ Diarrhea ❑ Constipation
- ❑ Diverticulosis ❑ Blood in stool
- ❑ Hemorrhoids ❑ Hernia
- ❑ Gall bladder trouble
- ❑ Jaundice ❑ Hepatitis
- ❑ Urine infections - frequent
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Control of urination
- ❑ Decreased force in urination
- ❑ Kidney stones
- ❑ Venereal disease

- ❑ Chronic fatigue
- ❑ Weight loss - recent
- ❑ Anemia ❑ Bruise easily
- ❑ Cancer
- ❑ Diabetes ❑ Thyroid disease
- ❑ Convulsions/Seizures
- ❑ Stroke
- ❑ Tremor / Hands shaking
- ❑ Numbness / Tingling sensation
- ❑ Headaches - frequent
- ❑ Arthritis / Rheumatism ❑ Gout
- ❑ Back pain - recurrent
- ❑ Bone fracture / Joint injury
- ❑ Foot pain ❑ Cold numb feet
- ❑ Rashes ❑ Hives
- ❑ Psoriasis ❑ Eczema
- ❑ Sleeping - difficulty
- ❑ Nervousness ❑ Depression
- ❑ Memory loss ❑ Mental illness
- ❑ Moodiness ❑ Phobias
- ❑ Recent hair loss

- ❑ Herpes ❑ Chlamydia
- ❑ Chicken Pox ❑ Polio ❑ Mumps
- ❑ Measles ❑ German Measles
- ❑ Rheumatic ❑ Scarlet fever ❑ T.B.
- ❑ Alcohol _____ oz. per week
- ❑ Smoking _____ cig. per day
- ❑ Coffee/Tea _____ cups per day

IMMUNIZATION	YEAR OF LAST INJECTION		
___ PNEUMONIA	___ FLU	___ TETANUS	
___ DIPTHERIA	___ MEASLES	___ MUMPS	
___ RUBELLA	___ POLIO	___ HEPATITIS	

Females - Menstrual History
Age of onset _____ ❑ Reg ❑ Irreg
❑ Pain / Cramps with menstrual flow
No. of Pregnancies _____
No. of Live Births _____
No. of Miscarriages _____
Birth Control method _____
❑ Flushing / Menopause