

TO BE COMPLETED BY PATIENT - PLEASE PRINT

# HEALTH QUESTIONNAIRE

REASON FOR VISIT  ANNUAL EXAM  EMOTIONAL PROBLEM  INJURY / ACCIDENT  WORKMEN'S COMP  PRE-EMPLOYMENT  OTHER - EXPLAIN

FAMILY HISTORY	ALIVE & WELL	DECEASED	COMMENTS	HIGH BLOOD PRESSURE	HEART DISEASE	EPILEPSY	DIABETES	CANCER	ASTHMA	HAYFEVER	ARTHRITIS	KIDNEY DISEASE	GLAUCOMA	STROKE	MIGRAINE	MENTAL ILLNESS	ALCOHOLISM	BLEEDS EASILY	ANEMIA	PSORIASIS	ECZEMA		
				FATHER																			
MOTHER																							
BROS / SIS																							
BROS / SIS																							
BROS / SIS																							
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.

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

MEDICATIONS	NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN

**DRUG 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) \_\_\_\_\_

<input type="checkbox"/> Decreased hearing	<input type="checkbox"/> Leg pain when walking	<input type="checkbox"/> Chronic fatigue	<input type="checkbox"/> Herpes	<input type="checkbox"/> Chlamydia	<input type="checkbox"/>
<input type="checkbox"/> Ringing in ear	<input type="checkbox"/> Varicose veins <input type="checkbox"/> Phlebitis	<input type="checkbox"/> Weight loss - recent	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Polio	<input type="checkbox"/> Mumps
<input type="checkbox"/> Ear infections - frequent	<input type="checkbox"/> Loss of appetite - recent	<input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily	<input type="checkbox"/> Measles	<input type="checkbox"/> German Measles	
<input type="checkbox"/> Dizzy Spells <input type="checkbox"/> Glaucoma	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Cancer	<input type="checkbox"/> Rheumatic	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> T.B.
<input type="checkbox"/> Failing vision <input type="checkbox"/> Cataracts	<input type="checkbox"/> Indigestion or heartburn	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease	<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"/> Double or blurred vision	<input type="checkbox"/> Persistent Nausea / Vomiting	<input type="checkbox"/> Convulsions / Seizures	<input type="checkbox"/> Stroke		
<input type="checkbox"/> Eye infections - frequent	<input type="checkbox"/> Peptic ulcers	<input type="checkbox"/> Tremor / Hands shaking	<input type="checkbox"/> Numbness / Tingling sensations		
<input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sinusitis	<input type="checkbox"/> Abdominal pain - chronic	<input type="checkbox"/> Headaches - frequent	<input type="checkbox"/> Arthritis / Rheumatism <input type="checkbox"/> Gout		
<input type="checkbox"/> Sore throats - frequent	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Back pain - recurrent	<input type="checkbox"/> Bone fracture / Joint injury		
<input type="checkbox"/> Hayfever <input type="checkbox"/> Allergies	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Foot pain <input type="checkbox"/> Cold numb feet	<input type="checkbox"/> Rash	<input type="checkbox"/> Hives	
<input type="checkbox"/> Hoarseness - prolonged	<input type="checkbox"/> Diverticulosis <input type="checkbox"/> Blood in stools	<input type="checkbox"/> Rashes <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema	<input type="checkbox"/> Sleeping - difficulty	<input type="checkbox"/> Nervousness <input type="checkbox"/> Depression	
<input type="checkbox"/> Pneumonia / Pleurisy	<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia	<input type="checkbox"/> Memory loss <input type="checkbox"/> Mental illness	<input type="checkbox"/> Moodiness <input type="checkbox"/> Phobias	<input type="checkbox"/> Recent hair loss	
<input type="checkbox"/> Bronchitis / Chronic cough	<input type="checkbox"/> Gall bladder trouble	<input type="checkbox"/> Urine infections - frequent	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Blood in urine	
<input type="checkbox"/> Asthma / Wheezing	<input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis	<input type="checkbox"/> Control of urination	<input type="checkbox"/> Decreased force in urination	<input type="checkbox"/> Kidney stones	
Shortness of breath:	<input type="checkbox"/> Urine infections - frequent	<input type="checkbox"/> Venereal Disease			
<input type="checkbox"/> On Exertion <input type="checkbox"/> Lying Flat	<input type="checkbox"/> Painful urination				
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Blood in urine				
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Control of urination				
<input type="checkbox"/> Heart Murmur <input type="checkbox"/> Palpitations	<input type="checkbox"/> Decreased force in urination				
<input type="checkbox"/> Irregular Pulse <input type="checkbox"/> Fainting spells	<input type="checkbox"/> Kidney stones				
<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> Venereal Disease				

**IMMUNIZATION** YEAR OF LAST INJECTION

\_\_\_ PNEUMONIA \_\_\_ FLU \_\_\_ TETANUS

\_\_\_ DIPHTHERIA \_\_\_ MEASLES \_\_\_ MUMPS

\_\_\_ RUBELLA \_\_\_ POLIO \_\_\_ HEPATITIS

Females - Date of Last Pap Test \_\_\_\_\_  
 Date of Last Mammogram \_\_\_\_\_  
**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