Health Questionnaire

Date: _____

Name: _____ Date of Birth: _____

Email: _____

Things I want to discuss with doctor today: _____

MEDICAL HISTORY

Chronic Medical Conditions:

- o High Blood Pressure
- o Heart Disease
- o Diabetes
- o Stroke
- o Cancer
- o Thyroid
- o Asthma
- o Emphysema/Lung Disease
- o Kidney Problems
- o Anemia
- o High Cholesterol
- o Glaucoma
- o Arthritis

Other Medical Problems: _____

Please list any previous **Surgeries/Procedures** (and year)

Non-surgical Hospitalizations:

Please list all **Medications**, vitamins and herbal supplements you are now taking, dose (in milligrams), and how often:

Medication/Substance Allergy or Intolerance:

Immunizations & Screenings (include last date):

- o Tetanus _____
- o Influenza _____
- o Pneumonia _____
- o Hepatitis _____
- o Tuberculosis _____
- o Shingles _____
- o Breast/Mammo _____
- o Pelvic/Pap _____
- o Colonoscopy _____
- o Other _____

SOCIAL HISTORY

Marital Status _____

Do you use tobacco now? ___Yes ___No

Type & daily amount _____

How long? _____

Have you used tobacco before? ___Yes ___No

Street drugs _____

Occupation _____

Significant Stressors? ___Yes ___No

Exercise type _____ times/wk _____

Water _____ cups per day

Caffeine _____ cups per day

Alcohol _____ drinks per week

Do you have Living Will form? ___Yes ___No

Would you like a Living Will? ___Yes ___No

Do you feel at risk for AIDS or sexually transmitted disease? ___YES ___No

Lived or traveled outside of USA or Canada? _____

FAMILY HISTORY

	Living (Yes/No)	Age/Age-at-death	List medical disorders (diabetes, cancer, stroke, etc)
Father	___Yes ___No	_____	_____
Mother	___Yes ___No	_____	_____
Spouse	___Yes ___No	_____	_____
	(# = Number)		
Brothers	# Living_____	_____	_____
	# Dead _____	_____	_____
Sisters	# Living_____	_____	_____
	# Dead _____	_____	_____
Children	# Living_____	_____	_____
	# Dead _____	_____	_____

REVIEW of SYSTEMS (Circle if frequent or bothersome)		Physician Notes
General	Appetite Gain/loss, Weight Gain/Loss, Fatigue, Fevers, Chills, Sweats, Intolerance of Heat/Cold, Daytime-sleepiness, Severe-snoring	
Skin	Change in: Skin/Hair/Nails, Rashes/Hives, Itching Growths, Sores not healing, Warts/Moles/Lumps	
Eyes	Eye pain, Blurry-vision, Double-vision, Vision loss, Flashes of light, Glaucoma, Cataracts	
ENT	Hearing loss, Ringing in ears, Nose: Stuffy/Runny, Nose-bleeds, Sore: Tongue/Mouth, Bleeding gums	
Lungs	Cough, Sputum production, Cough up blood, Wheezing, Short-of-breath when Resting/Exertion Difficulty breathing, Excessive snoring Asthma, Tuberculosis, Asbestos-exposure	
Heart	Chest Pain/Tightness/Pressure, Swelling in Feet/Legs, Odd/Fast-heartbeats, Heart flutter, Fainting, Dizziness Leg cramps walking, Awaken short of breath	
GI	Trouble swallowing, Heartburn, Stomach pain Nausea, Vomiting, Constipation, Diarrhea Blood-in-stool, Black tarry stool, Daily laxative use	
GU	Genital problems, Burning with urination, Bloody / Dark urine, Frequent / Night urination, Trouble Passing / controlling urine, Night-urination, Change-in-cycle, Change-in-sexual-function	
MSK	Back-pain, Joints:Pain/Stiffness/Swollen, Arthritis Recent bone fracture, Muscle Aches/Weakness	
Neuro	Headaches, Dizziness, Difficulty speaking, Numbness Tingling, Burning-discomfort, Balance/Coordination, Falls, Loss of strength, Memory loss, Seizures	
Psych	Anxiety, Depression, Thoughts of suicide, Trouble sleeping, Hear voices when alone	

Any thing else your doctor needs to know about? _____