



# HEALTH QUESTIONNAIRE

Patient's Name
MRN
DOB

Patient Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_

**Please indicate each of your chronic medical problems by marking the appropriate box below:**

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	Please list any other medical problems:
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Emphysema/Lung Disease	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Problems	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Anemia	
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Glaucoma	

**Please list all medications that you are now taking, strength (in milligrams) and how often. Include non-prescription medications, vitamins and herbal supplements.**


Are you allergic to any medications?  Yes  No If yes, please list them and the reaction they cause.


**Social History**

Tobacco _____ a day	Number of years _____ Year Quit _____
Alcohol _____ drinks per week	Caffeine _____ cups a day
Street Drugs _____	Low fat diet <input type="checkbox"/> Yes <input type="checkbox"/> No
Exercise _____ type	Times a week _____ minutes/session
Water _____ cups a day	Marital Status _____
# of Children _____	Occupation _____
Do you have a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, have you given us a copy? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Family History**

If any blood relative has suffered from the following conditions, check the box and indicate which relative.

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Emphysema/Lung Disease	
<input type="checkbox"/> Thyroid	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Cancer	

Patient Name: \_\_\_\_\_

**Please list any surgeries/hospitalizations (including the year):**


Are you under the care of any other doctor for any medical problems? \_\_\_\_\_

If so, whom and for what medical problem? \_\_\_\_\_

**Year of last:** Tetanus Shot \_\_\_\_\_ Flu Shot \_\_\_\_\_ Pneumonia Vaccine \_\_\_\_\_

**Women only:** Date of first day of last menstrual period: \_\_\_/\_\_\_/\_\_\_ Contraception Type \_\_\_\_\_

Number of: Pregnancies \_\_\_\_\_ Live Births \_\_\_\_\_

Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

Date of last: PAP \_\_\_\_\_ (Abnormal? \_\_\_\_\_) Mammogram \_\_\_\_\_ (Abnormal? \_\_\_\_\_)

Date of last: Osteoporosis Scan \_\_\_\_\_ Flushing/Menopausal Symptoms  Yes  No

Have you been a victim of abuse?  Yes  No

**Men only:** Date of last: Prostate Exam \_\_\_\_\_ Last PSA (Prostate Blood Test) \_\_\_\_\_

**Procedures (list year):**

Sigmoidoscopy	Colonoscopy	Stress Test
EKG	Cholesterol (normal Y/N)	Sugar (normal Y/N)

**Please place a checkmark next to any symptoms that you are currently having and indicate the year if the symptoms occurred in the past.**

<b>GENERAL</b>	<input type="checkbox"/> Fever	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Unexplained Weight Loss or Gain	<input type="checkbox"/> Fatigue
<b>SKIN</b>	<input type="checkbox"/> Rashes	<input type="checkbox"/> Cancers	<input type="checkbox"/> Change in Hair, Skin or Nails	
<b>EYES</b>	<input type="checkbox"/> Glasses	<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Pain	<input type="checkbox"/> Changing Vision <input type="checkbox"/> Discharge
<b>EAR NOSE</b>	<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Change in Hearing	<input type="checkbox"/> Persistent Runny Nose	
<b>THROAT</b>	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Change in Voice	<input type="checkbox"/> Sinus Trouble	
<b>HEART</b>	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Swelling in Ankles	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Heart Murmur
<b>LUNGS</b>	<input type="checkbox"/> Cough	<input type="checkbox"/> Short of Breath	<input type="checkbox"/> Wheeze	
<b>GASTRO- INTESTINAL</b>	<input type="checkbox"/> Nausea	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Change in Bowel Movements	
	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Heartburn		
<b>GENITO- URINARY</b>	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Painful or Frequent Urination	<input type="checkbox"/> Incontinence	
		<input type="checkbox"/> Sexually Transmitted Disease		
	<b>Women:</b>	<input type="checkbox"/> Vaginal Discharge	<input type="checkbox"/> Change in Menstrual Cycle or Sexual Function	
	<b>Men:</b>	<input type="checkbox"/> Testicular Pain	<input type="checkbox"/> Decreased Urinary Stream	
		<input type="checkbox"/> Penile Discharge	<input type="checkbox"/> Change in Sexual Function	
<b>ORTHOPEDIC</b>	<input type="checkbox"/> Painful Joints	<input type="checkbox"/> Muscle Weakness		
<b>NEURO/PSYCH</b>	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tremor	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Frequent Headaches
	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety		
<b>ALLERGY</b>	<input type="checkbox"/> Hives	<input type="checkbox"/> Hay Fever		
<b>CIRCULATION</b>	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Blood Clots		