HEALTH QUESTIONNAIRE

Name: ____

Reason for office visit: ____

FAMILY HISTORY: Indicate which relative has suffered any of the following.

1) Diabetes _________________
2) Heart Disease_____________
3) Stroke_____________________
4) Hypertension_______________
5) High Cholesterol______________
6) Alcoholism___________________
7) Hepatitis_____________________
8) Anemia____________________
9) Bleeding Disorders (ex. Hemophilia) ____________
10) Family History of Cancer? **If yes list who & type**.
____
____

INDICATE OPERATION INDICATE YEAR

Surgical History: ____
____

Hospital Admissions: ____
____

YOUR MEDICAL HISTORY:

Gastrointestinal Review of Systems

Indicate age when you had any of the following problems/symptoms or diseases

[ ] Loss of appetite-recent
[ ] Difficulty swallowing
[ ] Heartburn [ ] Peptic Ulcer
[ ] Persistent nausea / Vomiting
[ ] Abdominal pain-chronic
[ ] Gall bladder trouble
[ ] Hepatitis **if yes A [ ] B [ ] C [ ]**
[ ] Jaundice
[ ] Diarrhea [ ] Constipation
[ ] Diverticulosis / Colitis
[ ] Bloody or tarry stools
[ ] Hemorrhoids
[ ] Crohn's
[ ] Ulcerative Colitis

Past Medical History

Indicate age when you had any of the following problems/symptoms or diseases

[ ] Arthritis / Rheumatism
[ ] Asthma / Wheezing
[ ] COPD (emphysema or chronic bronchitis)
[ ] High blood pressure
[ ] Diabetes [ ] Thyroid disease
[ ] Seizures [ ] Stroke
[ ] Osteoporosis
[ ] Psoriasis [ ] Eczema
[ ] AIDS / HIV
[ ] Cancer (if yes type)________________
____

DO YOU CONSUME?

Alcohol _______ oz / week
Coffee / Tea _______ cups / day
[ ] Smoking ______ cig / day ____ # years
Year quit ______
[ ] Street drugs
[ ] Acupuncture [ ] tattoos

General Review of Systems

Indicate age when you had any of the following problems/symptoms or diseases.

[ ] Dizzy Spells [ ] Fainting spells
[ ] Double or blurred vision
[ ] Nose bleeds-recurrent
[ ] Seasonal Allergies
[ ] Sore throats-frequent
[ ] Hoarseness-prolonged
[ ] Pneumonia
[ ] Bronchitis / Chronic cough
[ ] Shortness of breath:
[ ] On exertion [ ] lying flat
[ ] Chest pain
[ ] Urination – Problem:
[ ] Overnight-more than twice
[ ] More than 8 times / 24 hrs.
[ ] Urgency to urinate with leakage
[ ] Decrease in force/flow painful
[ ] Blood in urine [ ] Kidney stones
[ ] Urine infections
[ ] Sexually Transmitted diseases
[ ] Weight loss [ ] Weight gain-recent
[ ] Anemia [ ] Bruise easily
[ ] Heart murmur
[ ] Swollen ankles
[ ] Irregular pulse
[ ] Palpitations
[ ] Headaches-frequent
[ ] Foot pain [ ] Gout
[ ] Back pain-recurrent
[ ] Blood transfusions
[ ] Sleeping or concentration difficulty
[ ] Depression [ ] Nervousness
[ ] Agitation [ ] Memory loss
[ ] Moodiness [ ] Suicidal thoughts
[ ] Phobias [ ] Mental illness
[ ] Rheumatic fever
[ ] Chicken pox [ ] Polio [ ] Mumps
[ ] Measles [ ] German measles
[ ] Tuberculosis [ ] Herpes

FEMALES

Menstrual flow:
[ ] Reg [ ] Irreg [ ] Pain / Cramping
Days of flow ______ length of cycle ____
Date-1st day of last period________
Number of:
[ ] Pregnancies
[ ] Miscarriages [ ] live births
Birth control method ______________
B. C. Pill _________________
[ ] Flushing / Menopause
Date of last PAP test ______________
[ ] Normal [ ] abnormal
Date of last mammogram ___________
[ ] Normal [ ] abnormal