

## Health Questionnaire

To be completed by the patient—please Print

**Name:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_ **Dr.** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_

**Chief Complaint(s):** (Please list in order of importance the present health concerns, symptoms, or problems you are experiencing):

\_\_\_\_\_

\_\_\_\_\_

**Hospitalizations:** If you have been in the hospital overnight-state the year-illness/operation (do not include pregnancies)

Year	Illness/Operation	Year	Illness/Operation

**Past Medical History:**

Have you ever had the following (circle yes or no, leave blank if uncertain)?

AIDS or HIV+	Y	N	Epilepsy	Y	N	Pneumonia	Y	N
Allergies	Y	N	Glaucoma	Y	N	Polio	Y	N
Anemia	Y	N	Heart Disease	Y	N	Rheumatic Fever	Y	N
Arthritis	Y	N	Hemorrhoids	Y	N	Scarlet Fever	Y	N
Asthma	Y	N	Hepatitis	Y	N	Stroke	Y	N
Anxiety/ Depression/ Panic Disorder	Y	N	Hernia	Y	N	Thyroid Disease	Y	N
Back trouble	Y	N	High or low B/P	Y	N	Transfusions	Y	N
Bladder infections	Y	N	Hives or eczema	Y	N	Tuberculosis	Y	N
Bleeding tendency	Y	N	Infectious mono	Y	N	Ulcer	Y	N
Bronchitis	Y	N	Kidney disease	Y	N	Venereal disease	Y	N
Cancer	Y	N	Measles	Y	N	Whooping Cough	Y	N
Chicken pox	Y	N	Migraines	Y	N	Any other disease (please state below)	Y	N
Diabetes	Y	N	Mitral valve	Y	N			
Diphtheria	Y	N	Mumps	Y	N			

**Alternative Therapies:**

Herbs	Y	N	Vitamins	Y	N	Chiropractic	Y	N
Homeopathic	Y	N	Acupuncture	Y	N	Massage Therapy	Y	N

**Family History:**

Has any blood relative had any of the following? (circle **yes** or **no**, leave blank if uncertain)

			Relationship				Relationship
Allergies	Y	N		Epilepsy	Y	N	
Anemia	Y	N		Heart disease	Y	N	
Anxiety/Depression	Y	N		High blood pressure	Y	N	
Bleeding tendency	Y	N		Migraines	Y	N	
Cancer	Y	N		Stroke	Y	N	
Diabetes	Y	N		Tuberculosis	Y	N	

**Medications:**

**Dosage:**

**Times/Day**

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**Social History:**

Tobacco	Y	N	# Packs per day ___ for ___ years	Quit smoking? Y N	When?
Alcohol	Y	N	# Drinks per week		
Caffeine	Y	N	# Cups per day		
Illegal Drugs	Y	N	Type:		
Exercise	Y	N	Times per week		

**The last time you had a (list year):**

	Year		Year
Flu Vaccine		Tetanus shot	
Hepatitis		TB test	
Pneumonia shot		Rubella Vaccine	
Stool blood test		Rectal exam	
Sigmoid exam		Eye exam	
Cholesterol test		PSA (men 50 and over)	

**FOR WOMEN ONLY:**

Age at onset of menstrual period: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_  
 Use Birth Control? Yes No Type: \_\_\_\_\_  
 Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_  
 Number of abortions: \_\_\_\_\_ Number of miscarriages: \_\_\_\_\_

**Year of last:**

Breast exam \_\_\_\_\_ Results: \_\_\_\_\_  
 Mammogram \_\_\_\_\_ Results: \_\_\_\_\_  
 Pap \_\_\_\_\_ Results: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_