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**

_____
_____
_____
_____
_____
_____
_____

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: _____