

Health Questionnaire

Name	Today's Date	Date of Birth
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Family History Please note if any blood relative has any of the following conditions.

Condition	Relative(s)	Condition	Relative(s)
Epilepsy		Osteoporosis	
Migraine		Arthritis	
Mental Illness		Heart disease	
Glaucoma		Stroke	
Diabetes		High Blood Pressure	
Thyroid		High Cholesterol	
Hayfever		Alcoholism	
Asthma		Hepatitis	
Anemia		Cancer	
Bleeds easily		Other	

Hospital Admissions (Not Including Pregnancies)

Year	Illness or Operation	Year	Illness or Operation

Medications You Are Currently Taking (Including those you buy without a prescription)

Allergies to Medications

Supplements (Attach list if necessary)

Vaccine History

Vaccine	Year of Last	Vaccine	Year of Last
Tetanus/Td		Tdap (Tetanus, Diphtheria, Whooping Cough)	
Influenza (flu)		MMR (Red Measles, Mumps, Measles)	
Pneumonia		Meningitis	
Hepatitis A		Chicken Pox	
Hepatitis B			
Whooping Cough			

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Medical History Mark "C" for current problems. Check (v) and indicate age when you had any of the following.

<input type="checkbox"/> Decreased hearing	<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia	<input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Ringing in ear	<input type="checkbox"/> Weight loss/gain <input type="checkbox"/> Appetite	<input type="checkbox"/> Chickenpox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps
<input type="checkbox"/> Ear infections - frequent	<input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily	<input type="checkbox"/> Measles <input type="checkbox"/> German measles
<input type="checkbox"/> Dizzy spells <input type="checkbox"/> Fainting spells	<input type="checkbox"/> Blood transfusions	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes
<input type="checkbox"/> Failing vision <input type="checkbox"/> Eye pain		<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> STD
Date of last eye exam _____	Urination - Overactive bladder	<input type="checkbox"/> Sexual problems/enjoyment
<input type="checkbox"/> Double or blurred vision	<input type="checkbox"/> Overnight more than twice	<input type="checkbox"/> Decreased life enjoyment
<input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sinus trouble	<input type="checkbox"/> More than 8 times in 24 hours	<input type="checkbox"/> Decreased work performance
<input type="checkbox"/> Sore throats - frequent	<input type="checkbox"/> Urgency to urinate <input type="checkbox"/> with leakage	
<input type="checkbox"/> Hoarseness - prolonged	<input type="checkbox"/> Decrease in force/flow <input type="checkbox"/> painful	<input type="checkbox"/> Alcohol _____ oz. per week
<input type="checkbox"/> Hayfever/Allergies	<input type="checkbox"/> urine leakage w/ exercise/movement	<input type="checkbox"/> Coffee/Tea _____ cups per day
<input type="checkbox"/> Pneumonia/Pleurisy	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Smoking - cig/day _____ years _____
<input type="checkbox"/> Bronchitis/Chronic cough	<input type="checkbox"/> Urine infections - frequent	Year quit _____
<input type="checkbox"/> Asthma/Wheezing	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Exercise _____
Date of last TB test _____		<input type="checkbox"/> Street drugs _____
Shortness of breath:	<input type="checkbox"/> Decreased energy/endurance, Fatigue	<input type="checkbox"/> Unwanted facial hair
<input type="checkbox"/> on exertion <input type="checkbox"/> lying flat	<input type="checkbox"/> Cancer Type: _____	Hair loss: <input type="checkbox"/> Progressive <input type="checkbox"/> Recent
<input type="checkbox"/> in the past week <input type="checkbox"/> affects lifestyle	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure	<input type="checkbox"/> Thyroid disease	MALES <input type="checkbox"/> Prostate Problems
Date of last cholesterol test _____	<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke	
<input type="checkbox"/> Heart murmur <input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Tremor/hands shaking	FEMALES - Please complete
<input type="checkbox"/> Irregular pulse <input type="checkbox"/> Palpitations	<input type="checkbox"/> Headaches <input type="checkbox"/> Numbness: Where _____	Menstrual flow:
<input type="checkbox"/> Leg pain - when walking	<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain/Cramps
<input type="checkbox"/> Varicose veins/Phlebitis	<input type="checkbox"/> Bone fracture/joint injury	Days of flow _____ Days in cycle _____
<input type="checkbox"/> Cold numb feet	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Back pain	Date - 1st day of last period _____
<input type="checkbox"/> Loss of appetite - recent	<input type="checkbox"/> Foot pain <input type="checkbox"/> Gout	Number of:
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Rashes <input type="checkbox"/> Hives	Pregnancies _____ Abortions _____
<input type="checkbox"/> Heartburn <input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema	Miscarriages _____ Live births _____
<input type="checkbox"/> Aspirin/Arthritis/Pain pills	<input type="checkbox"/> Concentration problems	Birth control method _____
<input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Gallbladder problems	<input type="checkbox"/> Depression <input type="checkbox"/> Nervousness	Name of b.c. pill _____
<input type="checkbox"/> Jaundice/Hepatitis	<input type="checkbox"/> Agitation <input type="checkbox"/> Memory loss	<input type="checkbox"/> Flushing/Menopause
<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Moodiness <input type="checkbox"/> Suicidal thoughts	<input type="checkbox"/> Pain/Bleeding during or after sex
<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bloating/discomfort	<input type="checkbox"/> Feelings of worthlessness	<input type="checkbox"/> Migraine <input type="checkbox"/> with nausea
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Phobias <input type="checkbox"/> Mental illness	Date of last Pap test _____
<input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis	<input type="checkbox"/> Sleep problems - how long _____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
<input type="checkbox"/> Inflammatory bowel disease	How frequent _____	Date of last mammogram _____
<input type="checkbox"/> Bloody/tarry stools	Not waking refreshed _____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
<input type="checkbox"/> Test for blood in stools _____		

Last Revised 9/12/2011

Notes

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