

# Health Questionnaire

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Phone \_\_\_\_\_

**History of Past Illness:** (circle answer)

|                  |     |    |              |     |    |
|------------------|-----|----|--------------|-----|----|
| Measles          | Yes | No | Mumps        | Yes | No |
| Diabetes         | Yes | No | Chicken Pox  | Yes | No |
| Rheumatic Fever  | Yes | No | Tuberculosis | Yes | No |
| Venereal Disease | Yes | No | Stroke       | Yes | No |

If yes, Explain: \_\_\_\_\_

Have you had any serious illness? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been hospitalized or placed under extended medical care? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had any surgeries? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had any broken bones? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had any head injuries? Yes \_\_\_\_\_ No \_\_\_\_\_

**Family History:**

| Relative         | Age | Health | If Deceased, Cause |
|------------------|-----|--------|--------------------|
| Father           |     |        |                    |
| Mother           |     |        |                    |
| Brother / Sister |     |        |                    |
| Brother / Sister |     |        |                    |
| Daughter / Son   |     |        |                    |
| Daughter / Son   |     |        |                    |
| Spouse           |     |        |                    |
|                  |     |        |                    |
|                  |     |        |                    |

**Has any blood relative ever had:** (circle answer)

|                         |     |    |                   |     |    |
|-------------------------|-----|----|-------------------|-----|----|
| Cancer                  | Yes | No | Tuberculosis      | Yes | No |
| Diabetes                | Yes | No | Heart Trouble     | Yes | No |
| Convulsions             | Yes | No | Suicide           | Yes | No |
| Mental Illness          | Yes | No | Bleeding Tendency | Yes | No |
| Gout or Other Arthritis | Yes | No | Other: _____      |     |    |

**Social History:** (circle where appropriate)

Marital Status?      Single      Married      Separated      Divorced      Widowed

Are you living with your spouse?      Yes      No

Is your sex life satisfactory?      Yes      No

Do you have any dependents at home?      Yes      No

Where were you born? \_\_\_\_\_

Alcohol consumption?      Never      Rarely      Moderately      Daily

Tobacco Use?      Smoke \_\_\_\_\_ pks/day      Non-Smoker

If Non-Smoker: Ever Smoked?      Yes      No

Are you exposed to fumes, dust or solvents?      Yes      No

If yes, list: \_\_\_\_\_

Occupation? \_\_\_\_\_

**Allergy History:** (circle answer)

Is there a history of skin reaction or other irritation or sickness following the injection or oral administration of:

|                                 |     |    |                                |     |    |
|---------------------------------|-----|----|--------------------------------|-----|----|
| Penicillin or other antibiotics | Yes | No | Morphine, codeine, Demerol     | Yes | No |
| Novocain or other anesthesia    | Yes | No | Aspirin or other pain remedies | Yes | No |
| Sulfa drugs                     | Yes | No | Tetanus antitoxin              | Yes | No |
| Adhesive tape                   | Yes | No | Iodine or Merthiolate          | Yes | No |

Food or other drugs? \_\_\_\_\_

List all drugs you are currently taking: \_\_\_\_\_

\_\_\_\_\_

## System Review

### General

|   |     |    |
|---|-----|----|
| Recent weight change?                                   | Yes | No |
| Have you been in good general health most of your life? | Yes | No |

### Head-Eyes-Ear-Nose-Throat

|                        |     |    |
|------------------------|-----|----|
| Eye disease or injury  | Yes | No |
| Do you wear glasses?   | Yes | No |
| Double vision          | Yes | No |
| Headaches              | Yes | No |
| Glaucoma               | Yes | No |
| Itching eyes           | Yes | No |
| Sneezing or runny nose | Yes | No |
| Nosebleeds             | Yes | No |
| Chronic sinus trouble  | Yes | No |
| Ear disease            | Yes | No |
| Impaired hearing       | Yes | No |
| Dizziness              | Yes | No |

### Neck

|                 |     |    |
|-----------------|-----|----|
| Stiffness       | Yes | No |
| Thyroid trouble | Yes | No |
| Enlarged glands | Yes | No |

### Respiratory

|                              |     |    |
|------------------------------|-----|----|
| Upper respiratory infections | Yes | No |
| Spitting up blood            | Yes | No |
| Chronic or frequent cough    | Yes | No |
| Asthma or wheezing           | Yes | No |
| Difficulty breathing         | Yes | No |
| Any trouble with lungs       | Yes | No |
| Pleurisy or pneumonia        | Yes | No |

### Gastrointestinal

|                                 |     |    |
|---------------------------------|-----|----|
| Peptic ulcer                    | Yes | No |
| Vomiting blood or food          | Yes | No |
| Gallbladder disease             | Yes | No |
| Liver trouble                   | Yes | No |
| Hepatitis                       | Yes | No |
| Painful bowel movements         | Yes | No |
| Bleeding with bowel movements   | Yes | No |
| Black stools                    | Yes | No |
| Hemorrhoids or piles            | Yes | No |
| Recent change in bowel habits   | Yes | No |
| Frequent diarrhea               | Yes | No |
| Heartburn or indigestion        | Yes | No |
| Does food stick in your throat? | Yes | No |

### Musculoskeletal

|  |     |    |
|--|-----|----|
| Varicose veins                               | Yes | No |
| Weakness of muscles or joints                | Yes | No |
| Any difficulty in walking                    | Yes | No |
| Any pain in calves or buttocks with walking? | Yes | No |
| relieved by rest?                            | Yes | No |

### Hematological

|   |     |    |
|---|-----|----|
| Are you slow to heal after cuts?  | Yes | No |
| Blood disease   | Yes | No |
| Phlebitis   | Yes | No |
| Anemia  | Yes | No |
| Have you ever had difficulty with bleeding excessively after tooth extraction or surgery? | Yes | No |

### Cardiovascular

|                                   |     |    |
|-----------------------------------|-----|----|
| Chest pain or angina pectoris     | Yes | No |
| Difficulty walking two blocks     | Yes | No |
| Heart trouble or heart attack     | Yes | No |
| High blood pressure               | Yes | No |
| Swelling of hands, feet or ankles | Yes | No |
| Heart murmur                      | Yes | No |
| Shortness of breath lying down    | Yes | No |

### Genitourinary

|                                  |     |    |
|----------------------------------|-----|----|
| Leakage of urine                 | Yes | No |
| Frequent urination               | Yes | No |
| Nighttime urination              | Yes | No |
| Burning or frequent urination    | Yes | No |
| Blood in urine                   | Yes | No |
| Kidney trouble                   | Yes | No |
| Urinary tract infections (UTI's) | Yes | No |

### Endocrine

|  |     |    |
|--|-----|----|
| Thyroid disease  | Yes | No |
| Hormone therapy  | Yes | No |
| Cramping or pain in abdomen                              | Yes | No |
| Have you become colder than before or skin become dryer? | Yes | No |

### Neuropsychiatric

|   |     |    |
|---|-----|----|
| Have you ever had a psychiatric check?            | Yes | No |
| Have you ever been advised to see a psychiatrist? | Yes | No |
| Have you ever had:                                |     |    |
| Convulsions                                       | Yes | No |
| Fainting spells                                   | Yes | No |
| Paralysis   | Yes | No |

### Gynecological (women)

|                        |       |
|------------------------|-------|
| Age periods started    | _____ |
| Pain with periods      | _____ |
| Date of last period    | _____ |
| Frequency of periods   | _____ |
| Number of pregnancies  | _____ |
| Number of children     | _____ |
| Number of miscarriages | _____ |

### Skin Disease

|                         |     |    |
|-------------------------|-----|----|
| Jaundice                | Yes | No |
| Hives, eczema or rashes | Yes | No |
| Abnormal pigmentation   | Yes | No |

Signature \_\_\_\_\_

Date \_\_\_\_\_