HEALTH QUESTIONNAIRE

DATE COMPLETED:_______________

NAME___________________________________ MARITAL STATUS: S / M / D / W AGE_____ SEX: M / F

OCCUPATION________________________________ EMPLOYER____

HEIGHT__________ WEIGHT__________ BIRTHDATE_______________ DOMINANT HAND: L / R

NAME OF YOUR PRIMARY CARE PHYSICIAN (INTERNIST OR PEDIATRICIAN):___________________________

SPORTS & HOBBIES:____

DRUG ALLERGIES: ☐ **NONE** OR LIST:____

VACCINATIONS: FLU VACCINATION ☐ YES ☐ NO PNEUMONIA VACCINATION (IF AGE 50+) ☐ YES ☐ NO

TOBACCO: ☐ NEVER SMOKED ☐ FORMER SMOKER ☐ CURRENT SMOKER ☐ YES, # OF PACKS PER DAY _____

ALCOHOL: ☐ NONE ☐ RECOVERING ALCOHOLIC ☐ YES, # OF DRINKS PER WEEK ______ / PER MONTH ______

SUBSTANCE/DRUG ABUSE: ☐ YES ☐ NO ☐ PRIOR HISTORY

MILITARY SERVICE: ☐ YES ☐ NO IF YES, WERE YOU INJURED DURING YOUR SERVICE: ☐ YES ☐ NO

PAST SURGERIES: ☐ **NONE** – OR LIST: (you may use the reverse side for space):

____

____

ILLNESSES: ☐ **NONE** – OR LIST:

____

____

INJURIES/HOSPITALIZATIONS: ☐ **NONE** – OR LIST: (you may use the reverse side for space):

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____

FAMILY HISTORY: IF ANY OF THE FOLLOWING HAVE RUN IN YOUR FAMILY, PLEASE CHECK:

FATHER: YOB_______ ☐ LIVING ☐ DECEASED ☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ HEART DISEASE ☐ STROKE ☐ CANCER ☐ UNKNOWN

MOTHER: YOB_______ ☐ LIVING ☐ DECEASED ☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ HEART DISEASE ☐ STROKE ☐ CANCER ☐ UNKNOWN

SYSTEM REVIEW: PLEASE CHECK IF YOU HAVE/HAD ANY OF THESE CONDITIONS:

GENERAL:	☐ **HEALTHY** ☐ ILL ☐ RECENT WEIGHT GAIN ______ LBS., LOSS ______ LBS. ☐ PREGNANT
HEART:	☐ **NORMAL** ☐ HIGH BLOOD PRESSURE ☐ HEART ATTACK ☐ ANGINA ☐ HEART FAILURE ☐ ARRHYTHMIA ☐ CORONARY ARTERY DISEASE
VASCULAR:	☐ **NORMAL** ☐ POOR CIRCULATION ☐ VARICOSE VEINS ☐ PHLEBITIS ☐ CAROTID ARTERY DISEASE ☐ LEG SWELLING / EDEMA ☐ HIGH CHOLESTEROL
LUNGS:	☐ **NORMAL** ☐ ASTHMA ☐ CHRONIC LUNG DISEASE ☐ BLOOD CLOTS IN LUNG ☐ PNEUMONIA
GASTROINTESTINAL:	☐ **NORMAL** ☐ HEARTBURN / REFLUX ☐ PEPTIC ULCER ☐ LIVER DISEASE ☐ OTHER:_______________________________
URINARY TRACT:	☐ **NORMAL** ☐ BLADDER INFECTION ☐ PROSTATE ENLARGMENT ☐ FREQUENT URINATION ☐ KIDNEY STONES ☐ KIDNEY FAILURE
ENDOCRINE:	☐ **NORMAL** ☐ DIABETES ☐ THYROID ABNORMALITY ☐ OTHER:_______________________________
HEMATOLOGIC:	☐ **NORMAL** ☐ BLOOD CLOTS ☐ ABNORMAL BLEEDING TENDENCIES ☐ BLOOD TRANSFUSION – (☐ YOUR OWN BLOOD, OR ☐ DONOR BLOOD)
NEUROLOGIC:	☐ **NORMAL** ☐ STROKE ☐ SEIZURES ☐ M.S. ☐ DEPRESSION
MUSCLES & JOINTS:	☐ **NORMAL** ☐ OSTEOARTHRITIS ☐ GOUT ☐ FIBROMYALGIA ☐ RHEUMATOID ARTHRITIS ☐ OTHER:_______________________

HEAD & NECK:	☐**NORMAL** ☐HEADACHE	☐VISUAL LOSS ☐OTHER:______	☐SINUS PROBLEMS	☐HEARING LOSS
SKIN:	☐**NORMAL**	☐CANCER	☐PSORIASIS ☐ECZEMA	☐RASHES
INFECTIOUS DISEASE:	☐**NORMAL**	☐HEPATITIS A / B / C	☐HIV	☐TUBERCULOSIS
CANCER:	☐**NONE**	☐YES, TYPE: ______		
BONES:	☐**NORMAL** ☐FRACTURES, IF YES, WHICH BONES? ______	☐OSTEOPENIA	☐OSTEOPOROSIS	

PLEASE USE THE SPACE BELOW TO EXPLAIN WHY YOU ARE SEEING THE DOCTOR. WHEN DID THE PROBLEM BEGIN?

SCALE OF PAIN, TODAY: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
(Circle One #) NO PAIN MODERATE WORST PAIN POSSIBLE

PLEASE USE THE REMAINDER OF THIS PAGE TO LIST YOUR CURRENT MEDICATIONS
(Please include over the counter, vitamins/supplements)

Medication(s):		Reason for use of the Medication(s):	
1)______	6)______	1)______	6)______
2)______	7)______	2)______	7)______
3)______	8)______	3)______	8)______
4)______	9)______	4)______	9)______
5)______	10)______	5)______	10)______

Pharmacy Name:______ City/Zip Code:______

DO NOT WRITE BELOW THIS LINE