HEALTH QUESTIONNAIRE

DATE COMPLETED: _____

NAME _____ MARITAL STATUS: S / M / D / W AGE _____ SEX: M / F

EMPLOYER _____ OCCUPATION _____

HEIGHT _____ WEIGHT _____ BIRTHDATE _____ DOMINANT HAND: L / R

NAME OF YOUR PRIMARY CARE PHYSICIAN (INTERNIST OR PEDIATRICIAN): _____
SPORTS & HOBBIES: _____
DRUG ALLERGIES: ☐ **NONE** OR LIST: _____

CURRENT MEDICATIONS: ☐ **NONE** OR LIST: (you may use the reverse side for space): _____
TOBACCO: ☐ NONE ☐ NEVER SMOKED ☐ FORMER SMOKER ☐ CURRENT SMOKER ☐ YES, # OF PACKS PER DAY _____
ALCOHOL: ☐ NONE ☐ RECOVERING ALCOHOLIC ☐ YES, #OF DRINKS PER WEEK _____
SUBSTANCE/DRUG ABUSE: ☐ YES ☐ NO ☐ PRIOR HISTORY
PAST SURGERIES / ILLNESSES /ACCIDENTS AND HOSPITALIZATIONS: ☐ NONE – OR LIST HERE:

_____
_____
_____
_____
_____

FAMILY HISTORY: IF ANY OF THE FOLLOWING HAVE RUN IN YOUR FAMILY, PLEASE CHECK:
FATHER: AGE ____ LIVING / DECEASED ☐ ALLERGIES ☐ CANCER ☐ TUBERCULOSIS ☐ DIABETES ☐ HEART DISEASE ☐ STROKE
MOTHER: AGE ____ LIVING / DECEASED ☐ ALLERGIES ☐ CANCER ☐ TUBERCULOSIS ☐ DIABETES ☐ HEART DISEASE ☐ STROKE

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

GENERAL: ☐ **HEALTHY** ☐ ILL RECENT WEIGHT GAIN ____ LBS., LOSS ____ LBS.
☐ PREGNANT

HEART/CIRCULATION: ☐ **NORMAL** ☐ HIGH BLOOD PRESSURE ☐ HEART ATTACK
☐ HEART FAILURE ☐ ANGINA ☐ ARRHYTHMIA ☐ POOR CIRCULATION

LUNGS: ☐ **NORMAL** ☐ ASTHMA ☐ CHRONIC LUNG DISEASE
☐ BLOOD CLOTS IN LUNG ☐ PNEUMONIA

GASTROINTESTINAL: ☐ **NORMAL** ☐ REFLUX ☐ PEPTIC ULCER ☐ LIVER DISEASE

URINARY TRACT: ☐ **NORMAL** ☐ BLADDER INFECTION ☐ PROSTATE ENLARGEMENT
☐ FREQUENT URINATION ☐ KIDNEY STONES ☐ KIDNEY FAILURE

ENDOCRINE: ☐ **NORMAL** ☐ DIABETES ☐ THYROID ABNORMALITY ☐ OTHER

HEMATOLOGIC: ☐ **NORMAL** ☐ BLOOD CLOTS ☐ TRANSFUSION – (☐ YOUR OWN BLOOD, OR
☐ DONOR BLOOD) ☐ ABNORMAL BLEEDING TENDENCIES

NEUROLOGIC: ☐ **NORMAL** ☐ STROKE ☐ SEIZURES ☐ M.S. ☐ DEPRESSION

MUSCLES & JOINTS: ☐ **NORMAL** ☐ OSTEOARTHRITIS ☐ RHEUMATOID ☐ FIBROMYALGIA
☐ GOUT

HEAD & NECK: ☐ **NORMAL** ☐ HEADACHES ☐ SINUS PROBLEMS ☐ HEARING LOSS
☐ VISUAL LOSS

SKIN:	☐ **NORMAL**	☐ CANCER	☐ PSORIASIS	☐ ECZEMA	☐ RASHES
INFECTIONS DISEASE:	☐ **NONE**	☐ HEPATITIS A / B / C	☐ HIV	☐ TUBERCULOSIS	
CANCER:	☐ **NONE**	☐ YES, TYPE: _____			
BONES:	☐ **NORMAL**	☐ OSTEOPOROSIS	☐ FRACTURES, IF YES, WHICH BONES? _____		

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

PLEASE USE THE REMAINDER OF THIS PAGE TO LIST YOUR CURRENT MEDICATIONS, IF ADDITIONAL SPACE NEEDED FROM THE FRONT

DO NOT WRITE BELOW THIS LINE