

HEALTH QUESTIONNAIRE

First Name, Last Name:

Date of Birth:

Reason for Visit:

Family History IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE.

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|-------------------|-------------------|-------------------|----------------------|
| 1) EPILEPSY | 6) THROID | 11) OSTEOPOROSIS | 16) HIGH CHOLESTEROL |
| 2) MIGRAINE | 7) HAYFEVER | 12) ARTHRITIS | 17) ALCOHOLSM |
| 3) MENTAL ILLNESS | 8) ASTHMA | 13) HEART DISEASE | 18) CANCER |
| 4) GLAUCOMA | 9) ANEMIA | 14) STROKE | |
| 5) DIABETES | 10) BLEEDS EASILY | 15) HYPERTENSION | |

HOSPITAL ADMISSIONS	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION
<i>Not including pregnancies</i>				

LIST ALL MEDICATIONS YOU ARE NOW TAKING -	INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION	ALLERGIES	VACCINE	YEAR OF LAST	TEST / EXAM
			TETANUS / TD	___	RECTAL/STOOL ___
			INFLUENZA (FLU)	___	CHOLESTERAL ___
			PNEUMONIA	___	EYE _____
			TUBERCULOSIS	___	_____
			HEPATITIS	___	_____

MEDICAL HISTORY MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWIGN SYMPTOMS OR DISEASES.

<input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Ringing in Ear <input type="checkbox"/> Ear Infections - <i>frequent</i> <input type="checkbox"/> Dizzy Spells <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Fading Vision <input type="checkbox"/> Eye Pain <input type="checkbox"/> Double or Blurred Vision <input type="checkbox"/> Eye Infections - <i>frequency</i> <input type="checkbox"/> Nose Bleeds - <i>recurrent</i> <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Sore Throat - <i>frequent</i> <input type="checkbox"/> Hayfever / Allergies <input type="checkbox"/> Hoarseness - <i>prolonged</i> <input type="checkbox"/> Pneumonia / Pleurisy <input type="checkbox"/> Bronchitis / Chronic Cough <input type="checkbox"/> Asthma / Wheezing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> on exertion <input type="checkbox"/> lying flat <input type="checkbox"/> Chest pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> Irregular Pulse <input type="checkbox"/> Palpitations <input type="checkbox"/> Leg pain – <i>when walking</i> <input type="checkbox"/> Varicose Veins – Phlebitis <input type="checkbox"/> Loss of Appetite – <i>recent</i> <input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Heartburn <input type="checkbox"/> Peptic Ulcer <input type="checkbox"/> <i>Persistent</i> Nausea / Vomiting <input type="checkbox"/> Abdominal Pain – <i>chronic</i> <input type="checkbox"/> Gall Bladder Trouble <input type="checkbox"/> Jaundice / Hepatitis <input type="checkbox"/> Change in Bowel Habits <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's / Colitis <input type="checkbox"/> Bloody or Tarry Stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia <input type="checkbox"/> Urine Infections - <i>frequent</i> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney Stones Urination - <input type="checkbox"/> Overnight > than twice <input type="checkbox"/> Painful <input type="checkbox"/> Loss of Control <input type="checkbox"/> Decrease in Force / Flow <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Urethral Discharge <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Weight Loss – recent <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tremor / Hands Shaking <input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Numbness / Tingling Sensations <input type="checkbox"/> Headaches - <i>frequent</i> <input type="checkbox"/> Arthritis / Rheumatism <input type="checkbox"/> Back Pain - <i>recurrent</i> <input type="checkbox"/> Bone Fracture / Joint Injury <input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Foot Pain <input type="checkbox"/> Cold Numb Feet <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Sleeping – <i>difficulty</i> <input type="checkbox"/> Depression <input type="checkbox"/> Memory Loss <input type="checkbox"/> Moodiness – <i>excessive</i> <input type="checkbox"/> Mental Illness <input type="checkbox"/> Phobias <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes <input type="checkbox"/> Alcohol _____oz. Per week <input type="checkbox"/> Smoking ___cig/day. # yrs.____ Yr. Quit _____ <input type="checkbox"/> Coffee / Tea ___cups per day <input type="checkbox"/> Regular Exercise	MALES - <input type="checkbox"/> Prostate <input type="checkbox"/> PSA test FEMALES – <i>Please complete</i> Menstrual Flow: <input type="checkbox"/> Reg <input type="checkbox"/> Irreg <input type="checkbox"/> Pain / Cramps Days of flow___ Length of Cycle___ Date – 1 st day of last period_____ <input type="checkbox"/> Pain / Bleeding during or after intercourse Number of: Pregnancies___ Abortions___ Miscarriages___ Live Births___ Birth Control Method_____ B.C. Pill (name)_____ <input type="checkbox"/> Flushing / Menopause Date of last PAP Test_____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Date of Last Mammogram_____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
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