

# 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  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

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**SKIN:**                     NORMAL       CANCER       PSORIASIS       ECZEMA       RASHES

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**INFECTIONS DISEASE:**    NONE             HEPATITIS A / B / C       HIV             TUBERCULOSIS

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**CANCER:**                     NONE             YES, TYPE: \_\_\_\_\_

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**BONES:**                     NORMAL       OSTEOPOROSIS       FRACTURES, IF YES, WHICH BONES? \_\_\_\_\_

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**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

