HEALTH QUESTIONNAIRE

REASON FOR VISIT	
FAMILY HISTORY	IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, PLEASE CIRCLE THE NUMBER AND INDICATE WHICH RELATIVE

1) EPILEPSY	6) THYROID	11) OSTEOPOROSIS	16) HIGH CHOLESTEROL	
2) MIGRANE	7) HAYFEVER	12) ARTHRITIS	17) ALCOHOLISM	
3) MENTAL ILLNESS	8) ASTHMA	13) HEART DISEASE	18) CANCER	
4) GLAUCOMA	9) ANEMIA	14) STROKE	19)	
5) DIABETES	10) BLEEDS EASILY	15) HYPERTENSION	20)	

HOSPITAL ADMISSIONS	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION
Not including pregnancies				

LIST ALL MEDICATIONS YOU ARE NOW TAKING – INCLUDING THOSE YOU BUY WITHOUT PRISCRIPTION	ALLERGIES	VACCINE	TEST / EXAM
		TETANIS / Td _____	RECTAL / STOOL _____
		INFLUENZA (FLU) _____	CHOLESTEROL _____
		PNEUMONIA _____	EYE EXAM _____
		HEPATITIS _____	TB TEST _____
		_____	_____
		_____	_____

MEDICAL HISTORY *CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES MARK "C" FOR CURRENT PROBLEMS*

- □ Decreased hearing
- □ Ringing in ear
- □ Ear infections – *frequent*
- □ Dizzy spells
- □ Fainting spells
- □ Failing vision
- □ Eye pain
- □ Double or blurred vision
- □ Nose bleeds – *recurrent*
- □ Sinus trouble
- □ Soar throats – *frequent*
- □ Hoarseness – *prolonged*
- □ Hay fever / Allergies
- □ Pneumonia / Pleurisy
- □ Bronchitis / Chronic cough
- □ Asthma / Wheezing
- □ Shortness of breath:
  - □ on exertion
- □ Loss of appetite – *recent*
- □ Difficulty swallowing
- □ Heartburn
- □ Peptic Ulcer
- □ Persistent nausea / Vomiting
- □ Abdominal pain – *chronic*
- □ Gall bladder trouble
- □ Jaundice / Hepatitis
- □ Diarrhea
- □ Constipation
- □ Diverticulosis
- □ Crohn's / Colitis
- □ Bloody or tarry stools
- □ Hemorrhoids
- □ Hernia
- □ Urine infections – *frequent*
- □ Blood in urine
- □ Kidney stones
- □ Urination
  - □ Overnight more than twice
- □ Weight gain – *recent*
- □ Anemia
- □ Bruise easily
- □ Cancer
- □ Diabetes
- □ Thyroid disease
- □ Seizures
- □ Stroke
- □ Tremor / Hands shaking
- □ Numbness / Tingling sensations
- □ Headaches – *frequent*
- □ Arthritis / Rheumatism
- □ Back pain – *recurrent*
- □ Bone fractures
- □ Joint injury
- □ Gout
- □ Osteoporosis
- □ Foot pain
- □ Cold, numb feet
- □ Rashes
- □ Nervousness
- □ Agitation
- □ Memory loss
- □ Moodiness
- □ Suicidal thoughts
- □ Phobias
- □ Mental illness
- □ Feelings of worthlessness
- □ Rheumatic fever
- □ Scarlet fever
- □ Chicken pox
- □ Polio
- □ Mumps
- □ Measles
- □ German measles
- □ Tuberculosis
- □ Herpes
- □ Alcohol ____ oz /

FEMALES- *please complete*

Menstrual flow

- □ Regular
- □ Irregular
- □ Pain / Cramps

Days of flow _____

Length of cycle _____

Date of 1st day of last period _____

- □ Pain / Bleeding during or after sex

Number of:

Pregnancies _____

Abortions _____

Miscarriages _____

Live births _____

Birth control method _____

□ lying flat
□ Chest pain
□ High blood pressure
□ Heart murmur
□ Swollen ankles
□ Irregular pulse
□ Palpitations
□ Leg pain – *when walking*
□ Varicose veins / Phlebitis

□ Painful
□ Loss of control
□ Decrease in force / *flow*
□ Venereal disease
□ Urethral discharge
□ Chronic fatigue
□ Weight loss

□ Hives
□ Psoriasis
□ Eczema
□ Sleeping or concentration difficulty
□ Depression

week
□ Smoking
____ cig / day
____ # years
year quit_____
□ Coffee / Tea
____ cups / day
□ Recent hair loss

____
B.C. Pill name
_____
____
□ Flushing / Menopause
Date of last PAP test
_____
____
□ Normal □ Abnormal
Date of last mammogram
_____
____
□ Normal □ Abnormal

OTHER:

NOTES