Health Questionnaire

Name: Date: Date of birth:

Chief Complaint:

Brief History of Problem:

Surgical History:

Past Medical History: (Please check if applicable)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Glaucoma
- ☐ Cancer
- ☐ Anemia
- ☐ Liver disease
- ☐ Blood Clots
- ☐ Epilepsy
- ☐ Gastrointestinal
- ☐ Gynecological Problems

Other:

Habits: Alcohol #drinks/week Cigarettes: #cig/day #years year quit

Other tobacco usage: Current frequency:

Caffeine #cups/day Recreational Drugs

Women only:

Date of last PAP test Normal? ☐ Abnormal? ☐

Date of last mammogram Normal? ☐ Abnormal? ☐

Date of last period (1st day) Menopausal symptoms?

Irregular periods? ☐ Menstrual pain?

Pre-menstrual complaints?:

History of pregnancies:

Family History:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Glaucoma
- ☐ Cancer
- ☐ Anemia
- ☐ Liver disease
- ☐ Blood Clots
- ☐ Epilepsy
- ☐ Osteoporosis

Other:

Allergies:

Current Medications:

Medication	Dosage	Action

Review of Current/Recent Symptoms: (check all those that are applicable)

General: ☐ Fever ☐ Chills ☐ Weight Loss ☐ Weakness

Skin: ☐ Rash ☐ Itching

Hematopoietic: ☐ Bruising ☐ Bleeding ☐ Anemia

HEENT: ☐ Vision change ☐ Double vision ☐ Glaucoma ☐ Hearing problems
☐ Vertigo

Respiratory: ☐ Cough ☐ Coughing Blood ☐ Shortness of Breath
☐ Infections

Cardiovascular: ☐ Chest Pain ☐ Murmurs ☐ Pain in legs with walking
☐ Swelling in the legs

Gastro-Intestinal ☐ Constipation ☐ Diarrhea ☐ Bleeding ☐ Hemorrhoids
☐ Indigestion ☐ Hepatitis

Genito-Urinary ☐ Burning ☐ Bleeding Leaking (incontinence) ☐ Flank pain
☐ Loss of erections

Muscle-skeletal: ☐ Joint pain ☐ Weakness ☐ Back pain ☐ Cramps

Neurologic: ☐ Headache ☐ Dizziness ☐ Seizures ☐ Blackouts
☐ Depression ☐ Sleeping problems

Other:

Other Comments:

_____ _____

Signature Date