

# HEALTH QUESTIONNAIRE

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**HISTORY OF PAST ILLNESS:** Have you had

Childhood:

Measles .....	No	Yes	Strokes .....	No	Yes	Rheumatic fever of heart disease .....	No	Yes
Mumps .....	No	Yes	Cancer .....	No	Yes	Congenital Abnormalities .....	No	Yes
Chicken Pox .....	No	Yes	Tuberculosis .....	No	Yes	Other serious diseases .....	No	Yes
Diabetes .....	No	Yes	Venereal disease .....	No	Yes			

Adult:

Do you or have you had a history of drug or alcohol abuse ..... No Yes

Have you had any serious illness? ..... No Yes

Have you ever been hospitalized or been under medical care for very long? ..... No Yes

If yes, for what reason? \_\_\_\_\_

Operations:

Have you had any surgery? ..... No Yes

List \_\_\_\_\_

IMMUNIZATION	No	Yes	Year
Measles			
Mumps			
Flu			
Tetanus			
Pneumonia			

Injuries:

Have you had any broken bones ..... No Yes

Have you had any head concussions or injuries ..... No Yes

Have you ever been knocked unconscious ..... No Yes

FAMILY HISTORY	If Living: Health		If Deceased		Has any blood relative ever had:		
	Age	Health	Age (at death) & Cause	Cause	No	Yes	Year
Father					Cancer	No	Yes
Mother					Tuberculosis	No	Yes
Brother/Sister					Diabetes	No	Yes
					Heart trouble	No	Yes
					High blood pressure	No	Yes
					Stroke	No	Yes
Husband/Wife					Convulsions	No	Yes
Son/Daughter					Suicide	No	Yes
					Mental Illness	No	Yes
					Bleeding Tendency	No	Yes
					Gout or other arthritis	No	Yes
					Hereditary Defects	No	Yes
					High Cholesterol	No	Yes

**SOCIAL HISTORY**

Circle One:

Single      Married      Separated      Divorced      Widowed

Are you living with your husband or wife? ..... No Yes

Is your sex life satisfactory? ..... No Yes

Do you have dependants at home? ..... No Yes

Alcoholic Beverages: Never \_\_\_\_\_ Rarely \_\_\_\_\_ Moderately \_\_\_\_\_ Daily \_\_\_\_\_ Ever? ..... No Yes

Tobacco: Cigarettes \_\_\_\_\_ Packs a day \_\_\_\_\_ Don't smoke \_\_\_\_\_ Ever smoked? ..... No Yes

Are you employed? Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

What is your job? \_\_\_\_\_

Are you exposed to fumes, dusts, or solvents? ..... No Yes

Education:

(year)

Grade School \_\_\_\_\_

High School \_\_\_\_\_

College \_\_\_\_\_

Postgraduate \_\_\_\_\_

How much time have you lost from work because of your health during the past?

Six Months? \_\_\_\_\_

One Year? \_\_\_\_\_

Five Years? \_\_\_\_\_

**SYSTEMIC REVIEW:** Do you have any of the following?

General:

Recent weight change? ..... No Yes

Have you been in good general health most of your life? .... No Yes

Skin:

Skin Disease ..... No Yes

Jaundice ..... No Yes

Hives, eczema or rash ..... No Yes

Frequent infection or boils ..... No Yes

Abnormal pigmentation ..... No Yes

Head-Eyes-Ears-Nose-Throat:

Eye disease or injury ..... No Yes

Do you wear glasses? ..... No Yes

Double vision ..... No Yes

Headaches ..... No Yes

Glaucoma ..... No Yes

Itching eyes or nose ..... No Yes

Head-Eyes-Earn-Nose-Throat (cont'd)

Sneezing or runny nose ..... No Yes

Nosebleeds ..... No Yes

Chronic sinus trouble ..... No Yes

Ear disease ..... No Yes

Impaired hearing ..... No Yes

Dizziness or transient episodes of unconsciousness ..... No Yes

Neck:

Stiffness ..... No Yes

Thyroid trouble ..... No Yes

Enlarged glands ..... No Yes

Respiratory:

URI (cold) now ..... No Yes

Spitting up blood ..... No Yes

Chronic or frequent cough ..... No Yes

**SYSTEMIC REVIEW:**

Respiratory:

Asthma or wheezing ..... No Yes  
 Difficulty breathing ..... No Yes  
 Any trouble with lungs ..... No Yes  
 Pleurisy or pneumonia ..... No Yes

Cardiovascular:

Chest pain or angina pectoris ..... No Yes  
 Shortness of breath with walking or lying down ..... No Yes  
 Difficulty walking two blocks ..... No Yes  
 Heart trouble or heart attacks ..... No Yes  
 High blood pressure ..... No Yes  
 Swelling of hands, feet, or ankles ..... No Yes  
 Awakening in the night smothering ..... No Yes  
 Heart murmur ..... No Yes

Gastrointestinal:

Peptic ulcer (stomach or duodenal) ..... No Yes  
 Vomiting blood or food ..... No Yes  
 Gallbladder disease ..... No Yes  
 Liver trouble ..... No Yes  
 Hepatitis ..... No Yes  
 Painful bowel movements ..... No Yes  
 Bleeding with bowel movements ..... No Yes  
 Black stools ..... No Yes  
 Hemorrhoids or piles ..... No Yes  
 Recent change in bowel habits ..... No Yes  
 Frequent diarrhea ..... No Yes  
 Heartburn or indigestion ..... No Yes  
 Cramping or pain in the abdomen ..... No Yes  
 Does food stick in throat ..... No Yes

Genitourinary:

Loss of urine ..... No Yes  
 Frequent urination ..... No Yes  
 Night time urinating ..... No Yes  
 Burning or painful urination ..... No Yes  
 Blood in urine ..... No Yes  
 Kidney trouble ..... No Yes  
 Kidney stones ..... No Yes  
 Bright's disease ..... No Yes

Gynecological:

Age periods started \_\_\_\_\_  
 How long do periods last? \_\_\_\_\_ Days

Gynecological (cont'd)

Number of pregnancies \_\_\_\_\_  
 Number of miscarriages \_\_\_\_\_  
 Date of last cancer smear and results \_\_\_\_\_  
 \_\_\_\_\_  
 Frequency of periods, every \_\_\_\_\_ days  
 Any pain with your periods ..... No Yes  
 Number of children \_\_\_\_\_ Ages \_\_\_\_\_  
 Date of last period \_\_\_\_\_

Locomotos-Musculoskeletal:

Varicose veins ..... No Yes  
 Weakness of muscles or joints ..... No Yes  
 Any difficulty in walking ..... No Yes  
 Any pain in calves or buttocks on walking relieved by rest ..... No Yes

Neuro-Psychiatric:

Have you ever had psychiatric care? ..... No Yes  
 Ever been advised to see a psychiatrist? ..... No Yes  
 Do you ever have fainting spells? ..... No Yes  
 Convulsions ..... No Yes  
 Paralysis ..... No Yes

Hematologic:

Are you slow to heal after cuts? ..... No Yes  
 Blood disease ..... No Yes  
 Anemia ..... No Yes  
 Phlebitis ..... No Yes  
 Have you had difficulty with bleeding excessively after tooth extraction or surgery? ..... No Yes  
 Any abnormal bruising or bleeding? ..... No Yes

Allergic:

Any allergies, including medication ..... No Yes

Endocrine:

Thyroid disease ..... No Yes  
 Hormone therapy ..... No Yes  
 Any change in hat or glove size? ..... No Yes  
 Any change in hair growth? ..... No Yes  
 Have you become colder than before or skin become dryer? ..... No Yes

HEIGHT \_\_\_\_\_  
 WEIGHT \_\_\_\_\_

**ALLERGIES AND SENSITIVITIES**

1. Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of:

	Circle One	What Drug, or Food?
Penicillin or other antibiotics ..... No Yes	Don't know	_____
Morphine, Codeine, Demerol or other narcotics ..... No Yes	Don't know	_____
Novocaine or other anaesthetics ..... No Yes	Don't know	_____
Aspirin, Empirin or other pain remedies ..... No Yes	Don't know	_____
Sulfa drugs ..... No Yes	Don't know	_____
Tetanus antitoxin or other serums ..... No Yes	Don't know	_____
Adhesive tape ..... No Yes	Don't know	_____
Lodine or Merthiolate ..... No Yes	Don't know	_____
Any other drug or medication ..... No Yes	Don't know	_____
Any foods, such as egg, milk, or chocolate ..... No Yes	Don't know	_____

2. Drugs recently taken: Within the past six months has patient taken:

Anticoagulants ..... No Yes Don't know  
 Tranquilizers ..... No Yes Don't know  
 Blood pressure medicine ..... No Yes Don't know

3. Do you take any vitamins, minerals, food supplements or herbs? If so, list name & dosage \_\_\_\_\_

\_\_\_\_\_  
 Doctor Date Signature of Patient