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HEALTH QUESTIONNAIRE

Patient Name: _____ Date: _____

Special problems or symptoms:

_____
_____
_____
_____

How long have you had this problem? _____

Have you ever consulted a physician for this problem? ……Yes ___ No ___

If yes: How did the doctor diagnose your problem?

_____
_____

How did the doctor treat your problem?

_____
_____

Are you allergic to any medications, foods, or other substances? ……Yes ___ No ___

If yes, what? _____
_____

List all medications you are currently taking:

NAME OF MEDICATION	DOSAGE	DIRECTIONS	DATE STARTED

If you need more space to write, please use the back of this form.

When was the last time you had a physical examination? _____

How much tobacco do you use? _____

How much alcohol do you drink? _____

List all illnesses (serious or chronic) and all hospitalizations starting with the most recent.

MO/YEAR	ILLNESS/HOPITALIZATION/OPERATION(S)	COMPLICATIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History:

	Age (if living)	Illnesses	If deceased, Age at death	Cause of Death
Mother:				
Grandmother (Maternal):				
Grandfather (Maternal):				
Father				
Grandmother (Paternal):				
Grandfather (Paternal):				
Brother:				
Brother:				
Sister:				
Sister:				
Children:				

Is there a family history of diabetes, heart disease, high blood pressure, cancer, or thyroid trouble? If so, please explain:

_____
_____
_____

Have you been diagnosed to have diabetes or thyroid disease? _____
_____

HEALTH QUESTIONNAIRE…continued

General State of Health:

Recent weight loss or gain: _____

Eyes, Ears, Nose & Throat:

Eye trouble: _____

Digestive:

Abdominal pain or problems: _____

Liver problems: _____

Blood or black in stools: _____

Appendicitis: _____

Rectal problems: _____

Heart and Lungs:

Chest pain: _____

Shortness of breath: _____

High blood pressure: _____

Lack of stamina: _____

Coughing: _____

Asthma: _____

Urinary:

Kidney stones, blood in urine: _____

Trouble urinating: _____

Gynecology:

Do you have periods? ……..Yes ___ No ___ Date of last period: _____

Age at first period: _____ Any problems with periods? _____

Any female disorders? _____

Bones and Joints:

Bone or joint problems: _____

Nervous System:

Seizures or Fainting: _____

Headaches or Dizziness: _____

Nervous Problems or Depression: _____