HEALTH QUESTIONNAIRE

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Confidential

Patient: ____ Birth Date: __________________ Today's Date: ________________

CONCERNS: What are your main problems or health concerns? Describe: 1) Onset of problem(s); 2) How has it changed over time; 3) What makes it better or worse; 4) Prior treatments or consultations

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ILLNESSES: List major illnesses

_______/____
Year Illness

_______/____
Year Illness

_______/____
Year Illness

HOSPITALIZATIONS: Including operations:

_______/____
Year Illness

_______/____
Year Illness

MEDICATIONS: Do you use: ☐ Prescription Drugs ☐ Over-the-Counter Medications ☐ Other ______________ ☐ None of the Above

Please list names, dosages and frequency of any checked above: ____

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ALLERGIES: Do you have any allergies to drugs? ☐ Yes ☐ No

Please list names and reactions experienced: ____

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Patient: ____ Birth Date: ________________ Today's Date: ______________

HEALTH HISTORY – REVIEW OF SYSTEMS:
Family History: Write the name of each family member below, follow the line across the page and mark a ✓ in those boxes which indicate their present state of health (good), (poor), or their death (write in the cause), and any of the illnesses that they have ever had. Print the names of your children (if any) in the spaces below.

	Age	Good Health	Poor Health	Deceased	Cause of Death	Allergies or Asthma	Anemia	Bleeding Disorder	Diabetes	Cancer or Tumor	Epilepsy	Glaucoma	Genetic Disease	Alcoholism	Kidney or Bladder Trouble	Stomach/Duodenal Ulcer	Anxiety/Depression	Rheumatism or Arthritis	High Blood Pressure	Heart Trouble	Stroke	Gout	Thyroid Disease
Father:																							
Mother:																							
Brother or Sisters:																							
Child:																							
Child:																							
Child:																							
Child:																							
All Grandparents (✔ for any affected)																							
Father's Relatives (write how many affected in each box)																							
Mother's Relatives (write how many affected in each box)																							
Your Health History (✔ for any of your illnesses)																							

Additional Illnesses or Problems: Mark a ✔ in the box next to any of the following that you have now or had every had:

□ eye disease
□ thyroid disease
□ eczema
□ asthma
□ bronchitis
□ emphysema
□ pneumonia
□ pancreatitis
□ liver disease
□ diverticulosis
□ hernia
□ hemorrhoids
□ neuralgia or neuritis
□ tension/anxiety
□ depression
□ childhood hyperactivity
□ chicken pox
□ German measles
□ scarlet fever
□ measles
□ mumps
□ polio
□ rheumatic fever
□ malaria
□ mononucleosis
□ venereal disease
□ yellow jaundice
□ Other_______________
□ Other_______________
□ broken bones____
□ injuries ____

LIFESTYLE AND HABITS:

Yes No

□ □ Have you lost or gained more than 5 pounds in the past year? □ Yes □ No
□ □ Do you drink alcoholic beverages? □ Yes □ No - ___beers/week ___ glasses of wine/week ___ mixed drinks/week
□ □ Do you use other intoxicants? □ Yes □ No - If so, what type? ____
□ □ Do you drink caffeinated beverages? □ Yes □ No - ___ coffee (cups/day) ___ tea(cups/day) ___ colas (12 oz/day)
□ □ Do you smoke? □ Yes □ No - If so, what?________________________ Pack/day______ How many years?_______
□ □ Do you work around toxic substances? □ Yes □ No - If so, what? ____
□ □ Do you sleep well and awaken rested? □ Yes □ No - How many hours per night?______
□ □ Do you exercise? □ Yes □ No - How long? _____Min. How often?_____times/wk What type?___________________
□ □ Can you run 2 blocks or go up 2 flights of stairs without difficulty? □ Yes □ No
□ □ Do you regularly eat breakfast? □ Yes □ No
□ □ Do you have a regular practice for your stress management?: □ Yes □ No
□ Exercise □ Hobbies □ Meditation/Prayer □ Yoga □ Other ______________________

Patient: ____ Birth Date: _________________ Today's Date: _______________

REVIEW OF SYSTEMS: Mark a ✔ if you have these symptoms **NOW.**

GENERAL
_____ Sleep disorder
_____ Weight changes
_____ Tend to be too hot or too cold
_____ Always hungry
_____ More thirst lately
_____ Shortness of breath at night
_____ Swelling in armpits, groin or neck
_____ Fatigue
_____ Fever
_____ Night sweating

HEAD AND NECK
_____ Numb or cold feet and hands
_____ Frequent headaches
_____ Neck pains
_____ Neck lumps or swelling
_____ Neck stiffness

EYES
_____ Eye trouble
_____ Wear glasses
_____ Blurry vision
_____ Eyesight worsening
_____ See double
_____ See halos around lights
_____ Eye pains or itching
_____ Discharge or watering eyes
_____ Light hurts eyes
_____ Last Exam (Year_____________)

EARS
_____ Hearing loss
_____ Earaches
_____ Drainage from ears
_____ Buzzing or ringing in ears
_____ Motion Sickness

MOUTH
_____ Dental problems
_____ Swelling in gums or jaws
_____ Sore tongue
_____ Taste changes
_____ Bleeding gums
_____ Grinds teeth
_____ Sore jaws
_____ Last Exam (Year_____________)

NOSE AND THROAT
_____ Congested nose
_____ Runny nose
_____ Sneezing spells
_____ Frequent head colds
_____ Nosebleeds
_____ Sore throat
_____ Enlarged tonsils
_____ Hoarse voice
_____ Difficulty swallowing

RESPIRATORY
_____ Wheezing or gasping breathing
_____ Coughing spells
_____ Cough up phlegm or mucus
_____ Cough up blood
_____ Frequent chest colds or bronchitis
_____ Shortness of breath
_____ Tuberculosis exposure
_____ Toxic inhalant exposure (e.g. asbestos, dusts, etc).

CARDIOVASCULAR
_____ High blood pressure
_____ Irregular heartbeat
_____ Racing heartbeat
_____ Palpitations/feel heart thumping
_____ Chest pains
_____ Dizzy spells
_____ Shortness of breath with exercise
_____ Stopped menstrual period (Year____)
_____ Can't breathe when lying down
_____ Swollen feet or ankles
_____ Leg cramps or aching
_____ Heart murmur
_____ Varicose veins
_____ Blood clots in legs

DIGESTIVE
_____ Heartburn
_____ Bloated stomach
_____ Belching
_____ Stomach pains
_____ Nausea
_____ Vomiting blood
_____ Constipation
_____ Loose stools or diarrhea
_____ Black stools
_____ Grey stools
_____ Hard stools
_____ Pain in rectum
_____ Rectal bleeding
_____ Hemorrhoids
_____ Ulcers
_____ Food allergy/intolerance
_____ Gallbladder trouble

MUSCULOSKELETAL
_____ Aching muscles
_____ Aching joints
_____ Swollen joints
_____ Stiffness in joints
_____ Back pains
_____ Back stiffness
_____ Painful feet
_____ Spinal curvature or scoliosis
_____ Chiropractic or osteopathic treatment
_____ Handicapped or disabled

URINARY
_____ Up at night to urinate ______ times
_____ Urinate more than 5-6 times a day
_____ Burning during urination
_____ Urine cloudy or bloody
_____ Urine brown or black
_____ Difficulty starting urine
_____ Difficulty holding urine
_____ Kidney stones
_____ Kidney or urinary infections

MALE GENITAL
_____ Weak urine stream
_____ Prostate trouble
_____ Discharge or burning in penis
_____ Swelling or lump in testicle
_____ Sexual difficulties
_____ Desire birth control information

FEMALE GENITAL
_____ Irregular cycles
_____ Painful periods
_____ Bleeding between periods
_____ Heavy menstrual bleeding
_____ Bleeding after intercourse
_____ Bloated or irritable before period
_____ Premenstrual tension syndrome
_____ Hot flashes
_____ Have taken hormones or birth control pills
_____ DES (diethylstilbestrol) exposure
_____ Lumps in breasts
_____ Nipple discharge
_____ Vaginal discharge or itching
_____ Pain with intercourse
_____ Last pap smear (Month____/Year_______)
_____ Number of pregnancies
_____ Number of miscarriages
_____ Number of therapeutic abortions
_____ Number of normal deliveries
_____ Number of living children
_____ Number of Caesarean operations
_____ Toxemia of pregnancy
_____ Pelvic surgery _____________________________
_____ Infertility
_____ Desire birth control information
_____ Current birth control method ___________________

SKIN
_____ Skin problems or rashes
_____ Itching of burning skin
_____ Bleed easily
_____ Skin cancer
_____ Changes in wart or mole
_____ Hives

NEUROLOGICAL
_____ Faintness
_____ Numbness or tingling
_____ Convulsions or seizures
_____ Change in handwriting
_____ Trembling or shaking
_____ Loss of consciousness
_____ Loss of coordination or balance
_____ Muscle weakness
_____ Sudden loss of vision
_____ Slurred speech

MOOD
_____ Difficulty concentrating
_____ Difficulty remembering
_____ Depressed or blue often
_____ Crying often
_____ Hopeless outlook
_____ Lose temper often
_____ Difficulty expressing feelings
_____ Troubled by frightening thoughts
_____ Thinking about ending life
_____ Worry a lot