CURRENT INSURANCE NUMBERS: _____ DATE _____

HEALTH QUESTIONNAIRE

THIS FORM IS TO HELP YOUR DOCTOR GIVE YOU BETTER HEALTH CARE. IT IS COMPLETELY CONFIDENTIAL AND WILL BE A PART OF YOUR MEDICAL RECORD.

Name _____ Birthdate Age _____

Home Address _____ City & State _____ Phone Number _____

Business Address _____ City & State _____ Bus. Phone _____

Please answer all questions. Circle YES or NO. Write in answers where indicated.

PAST HISTORY

DID YOU EVER HAVE AN OPERATION? . . . . . YES NO
IF YES, LIST OPERATIONS AND YEAR PERFORMED.

_____
_____
_____
_____
_____
_____
_____

DID YOU EVER HAVE A SERIOUS MEDICAL ILLNESS WHICH WAS NOT A SURGICAL OPERATION?. . . . . YES NO
IF YES, LIST ILLNESS AND YEAR OF ILLNESS.

_____
_____
_____
_____
_____
_____
_____

HAVE YOU EVER HAD A SERIOUS INJURY? . . . . . YES NO
IF YES, LIST INJURY AND DATE.

_____
_____
_____
_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? . . . . . YES NO
IF YES, LIST THE MEDICATION AND YOUR REACTION.

_____
_____
_____

FAMILY HISTORY

	LIVING		DECEASED	
	AGE	HEALTH	AGE	CAUSE
FATHER				
MOTHER				
BROTHERS				
SISTERS				

HAVE ANY RELATIVES EVER HAD THE FOLLOWING?

IF SO, WHOM?

DIABETES _____ GOITER _____
HEART TROUBLE _____ CANCER _____
HIGH BLOOD PRESSURE _____ TUBERCULOSIS _____
ARTHRITIS _____ STROKE _____
MIGRAINE _____ EPILEPSY _____
KIDNEY DISORDER _____ INSANITY _____

SOCIAL HISTORY

WHAT IS YOUR OCCUPATION? _____

CIRCLE IF YOU ARE: SINGLE–MARRIED–WIDOWED–SEPARATED–DIVORCED.

HOW MANY CHILDREN DO YOU HAVE? _____

HOW MUCH ALCOHOL DO YOU DRINK? _____

HOW MUCH DO YOU SMOKE? _____

HOW LONG HAVE YOU SMOKED? _____

WHEN DID YOU QUIT SMOKING? _____

LIST ALL MEDICATIONS YOU ARE TAKING:

_____
_____
_____
_____
_____
_____

DO YOU HAVE BAD HEADACHES? ..... YES NO

ARE HEADACHES COMMON IN YOUR FAMILY? ..... YES NO

HAVE YOU EVER SEEN DOUBLE? ..... YES NO

HAS YOUR EYESIGHT BLACKED OUT COMPLETELY? .. YES NO

ARE YOU BOTHERED BY DIZZY SPELLS? ..... YES NO

HAVE YOU EVER HAD A CONVULSION? ..... YES NO

DO YOU HAVE RINGING IN YOUR EARS? ..... YES NO

ARE YOU HARD OF HEARING? ..... YES NO

DO YOU HAVE NOSEBLEEDS? ..... YES NO

IS YOUR NOSE FREQUENTLY STOPPED UP? ..... YES NO

HAVE YOU HAD DIFFICULTY SWALLOWING? ..... YES NO

HAVE YOU HAD DIFFICULTY SPEAKING? ..... YES NO

DO YOU HAVE PERSISTENT HOARSENESS? ..... YES NO

DO YOU HAVE A FEELING OF A LUMP IN YOUR THROAT? ..... YES NO

DO YOU HAVE HAY FEVER? ..... YES NO

DO YOU HAVE ASTHMA? ..... YES NO

DO YOU COUGH FREQUENTLY? ..... YES NO

HAVE YOU EVER COUGHED UP BLOOD? ..... YES NO

DID YOU EVER LIVE WITH ANYONE WHO HAD TUBERCULOSIS? ..... YES NO

DO YOU HAVE CHEST PAIN? ..... YES NO

DOES VIGOROUS EXERTION CAUSE CHEST DISCOMFORT OR PRESSURE? ..... YES NO

ARE YOU SHORT OF BREATH? ..... YES NO

DO YOU BECOME WINDED AFTER WALKING UP ONE FLIGHT OF STAIRS? ..... YES NO

DO YOU SLEEP ON MORE THAN ONE PILLOW? ..... YES NO

HAVE YOU EVER AWAKENED SHORT OF BREATH? .... YES NO

DOES YOUR HEART THUMP OR SKIP? ..... YES NO

DO YOUR ANKLES SWELL ? ..... YES NO

HAVE YOU EVER BEEN TOLD YOU HAD HIGH BLOOD PRESSURE? ..... YES NO

HAVE YOU EVER BEEN TOLD THAT YOU HAD HEART TROUBLE? ..... YES NO

HAVE YOU HAD RHEUMATIC FEVER OR GROWING PAINS? ..... YES NO

HAVE YOU HAD HEART MURMUR? ..... YES NO

HAVE YOU EVER BEEN TOLD YOU HAD EMPHYSEMA? ..... YES NO

HAVE YOU LOST OR GAINED MORE THAN FIVE POUNDS IN THE PAST YEAR? ..... YES NO

IS YOUR APPETITE POOR? ..... YES NO

DO YOU CONSIDER YOURSELF OVERWEIGHT? ..... YES NO

DO YOU CONSIDER YOURSELF UNDERWEIGHT? ..... YES NO

DO YOUR SUFFER FROM INDIGESTION? ..... YES NO

DO YOU SUFFER FROM HEARTBURN? ..... YES NO

DO YOU SUFFER FROM GAS? ..... YES NO

DO YOU TAKE ANTACIDS SUCH AS TUMS, ROLAIDS OR BAKING SODA? ..... YES NO

ARE YOU OFTEN SICK TO YOUR STOMACH? ..... YES NO

DO YOU HAVE FREQUENT VOMITING SPELLS? ..... YES NO

HAVE YOU EVER VOMITED BLOOD? ..... YES NO

HAVE YOU EVER HAD AN ULCER? ..... YES NO

HAVE YOU EVER HAD GALLBLADDER DISEASE? ..... YES NO

HAVE YOU EVER HAD HEPATITIS? ..... YES NO

HAVE YOU EVER HAD JAUNDICE? ..... YES NO

HAVE YOU EVER HAD COLITIS? ..... YES NO

HAVE YOU EVER HAD SEVERE ABDOMINAL PAIN? ..... YES NO

HAVE YOU HAD ANY RECENT CHANGE IN YOUR BOWEL MOVEMENTS? ..... YES NO

DO YOU HAVE LOOSE BOWEL MOVEMENTS? ..... YES NO

DO YOU HAVE CONSTIPATION? ..... YES NO

DO YOU HAVE HEMORRHOIDS (PILES)? ..... YES NO

HAVE YOU EVER HAD BLOOD IN YOUR BOWEL MOVEMENTS? ..... YES NO

HAVE YOU EVER HAD BLACK BOWEL MOVEMENTS? ..... YES NO

WERE YOU EVER TREATED FOR 'BAD BLOOD' (VENEREAL DISEASE)? ..... YES NO

HAS A DOCTOR EVER SAID YOU HAD A HERNIA (RUPTURE)? ..... YES NO

HAVE YOU EVER PASSED BLOOD WHILE URINATING? ..... YES NO

DO YOU HAVE TROUBLE STARTING YOUR STREAM? ..... YES NO

DO YOU GET UP MORE THAN ONCE A NIGHT TO URINATE? ..... YES NO

DO YOU URINATE MORE THAN SIX TIMES DURING THE DAYTIME? ..... YES NO

HAVE YOU HAD SEVERE BURNING WHEN YOU URINATE? ..... YES NO

DO YOU LOSE CONTROL OF YOUR BLADDER? ..... YES NO

HAVE YOU EVER HAD A KIDNEY STONE? ..... YES NO

HAVE YOU EVER HAD A KIDNEY INFECTION? ..... YES NO

HAVE YOU EVER HAD A BLADDER INFECTION? ..... YES NO

DO YOU HAVE LOSS OF SEXUAL INTEREST? ..... YES NO

DO YOU HAVE LOSS OF SEXUAL ABILITY? ..... YES NO

HAVE YOU EVER HAD ARTHRITIS OR RHEUMATISM? ..... YES NO

ARE YOUR JOINTS EVER PAINFUL? ..... YES NO

ARE YOUR JOINTS EVER SWOLLEN? ..... YES NO

DO YOUR JOINTS FEEL STIFF IN THE MORNING? ..... YES NO

DURATION _____

DO YOU HAVE FREQUENT ACHING IN YOUR MUSCLES? ..... YES NO

HAVE YOU EVER HAD SUGAR IN YOUR URINE? ..... YES NO

HAVE YOU EVER HAD HIGH BLOOD SUGAR? ..... YES NO

DO YOU HAVE DIABETES IN YOUR FAMILY? ..... YES NO

DO YOU FEEL THIRSTY? ..... YES NO

HAVE YOU HAD BOILS OR OTHER SKIN INFECTIONS? ..... YES NO

DO YOU BECOME WEAK IF YOU DO NOT EAT? ..... YES NO

IF YES, WILL IT OCCUR BETWEEN ORDINARILY SPACED MEALS? ..... YES NO

DO YOU FREQUENTLY HAVE WEAK, SHAKY SPELLS WHICH ARE RELIEVED BY EATING? ..... YES NO

IF YES, WILL THIS OCCUR ONLY IF A REGULAR MEAL IS MISSED? ..... YES NO

HAVE YOU EVER TAKEN THYROID HORMONES? ..... YES NO

HAVE YOU EVER HAD A GOITER (THYROID ENLARGEMENT)? ..... YES NO

DO YOU HAVE BLEEDING GUMS? ..... YES NO

DO YOU BRUISE EASILY? ..... YES NO

HAVE YOU EVER BEEN ANEMIC? ..... YES NO

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ..... YES NO

DO YOU HAVE LUMPS IN YOUR NECK, UNDER YOUR ARMS OR IN YOUR GROIN? ..... YES NO

HAVE YOU EVER BEEN GIVEN CORTISONE? ..... YES NO

ARE YOU FREQUENTLY ILL? ..... YES NO

ARE YOU CONSIDERED A SICKLY PERSON? ..... YES NO

DO YOU HAVE DIFFICULTY FALLING ASLEEP? ..... YES NO

DO YOU HAVE DIFFICULTY STAYING ASLEEP? ..... YES NO

DO YOU AWAKEN BEFORE THE ALARM RINGS IN THE MORNING? ..... YES NO

DO YOU AWAKEN TIRED IN THE MORNING? ..... YES NO

DO YOU HAVE SPELLS OF COMPLETE EXHAUSTION? .. YES NO

DOES WORK TIRE YOU OUT COMPLETELY? ..... YES NO

DO YOU PUSH OR DRIVE YOURSELF MOST OF THE TIME? ..... YES NO

DOES WORRYING GET YOU DOWN? ..... YES NO

ARE YOU CONSIDERED A NERVOUS PERSON? ..... YES NO

DID YOU EVER HAVE A NERVOUS BREAKDOWN? ..... YES NO

DID ANYONE IN YOUR FAMILY EVER HAVE A NERVOUS BREAKDOWN? ..... YES NO

ARE YOUR FEELINGS EASILY HURT? ..... YES NO

DO PEOPLE MISUNDERSTAND YOU ? ..... YES NO

ARE YOU EASILY UPSET OR IRRITATED? ..... YES NO

DO YOU GET INTO A VIOLENT RAGE? ..... YES NO

DO YOU SHAKE OR TREMBLE? ..... YES NO

ARE YOU CONSTANTLY KEYED UP OR JITTERY? ..... YES NO

DO FRIGHTENING THOUGHTS KEEP COMING BACK IN YOUR MIND? ..... YES NO

IS IT HARD FOR YOU TO MAKE UP YOUR MIND? ..... YES NO

DO YOU OFTEN CRY? ..... YES NO

DO YOU FEEL UNHAPPY OR DEPRESSED? ..... YES NO

DO YOU FEEL MISERABLE OR BLUE? ..... YES NO

DOES LIFE LOOK HOPELESS? ..... YES NO

DO YOU OFTEN WISH YOU WERE AWAY FROM IT ALL? .. YES NO

DO YOU OFTEN WISH YOU WERE DEAD? ... YES NO

THIS SECTION FOR WOMEN PATIENTS ONLY

DO YOU HAVE PROBLEMS WITH YOUR PERIODS? .... YES NO

ARE YOUR PERIODS REGULAR? ..... YES NO

DO YOU HAVE SEVERE CRAMPS WITH YOUR PERIODS? ..... YES NO

DO YOU HAVE HOT FLASHES? ..... YES NO

ARE YOU BOTHERED BY AN IRRITATING VAGINAL DISCHARGE? ..... YES NO

COLOR OF DISCHARGE _____

DO YOU HAVE A DISCHARGE FROM YOUR BREASTS? ..... YES NO

HAVE YOU EVER BEEN PREGNANT? ..... YES NO

HAVE ANY OF YOUR BABIES WEIGHED 8 LBS. OR MORE AT BIRTH? ..... YES NO

HAVE YOU HAD A PAP SMEAR IN THE LAST 12 MONTHS? ..... YES NO

WHEN DID YOU HAVE YOUR LAST PERIOD?

HOW OLD WERE YOU WHEN YOUR PERIOD STARTED?