HEALTH QUESTIONNAIRE

PATIENT NAME	DOB:	TODAY'S DATE:

MEDICATIONS: List all Medications you are currently taking (include over the counter medications) If you need more space use back of this form.

ALLERGIES: List all Allergies to Medications. Write **"NONE"** if no known allergies.

MEDICAL HISTORY: Do you have or had any of the following?

	AIDS/HIV		COPD		Hepatitis		Multiple Sclerosis (MS)
	Alcoholism		Diabetes		Herpes/Shingles		Myocardial Infarction
	Anemia		Diverticulitis		High Blood Pressure		Osteoporosis
	Asthma		Fibromyalgia		____Kidney disease ___ Kidney stones		Pneumonia/Pleurisy
	____Arthritis ____ Rheumatoid		Gastric ulcers		Liver disease		Psoriasis
	Bronchitis		Glaucoma		Lupus		Seizures
	Cancer type: ___________________________		Heart disease type: _________________		Mental Illness: ___Anxiety ___Bipolar ___Depression __PTSD ___Schizophrenia		STD type:__________
	Chronic Pain		Heart murmur		Migraine		Stroke
	Colitis				MRSA		Thyroid disease
							Tuberculosis

SOCIAL HISTORY:

Current With drawl symptoms?:	**Smoking**:____yes_____no	**Coffee/Caffeine:**
Describe:	How many years? ______	_________cups per day
	How many per day:_____	**Sleeping at night:**
Overdose Ever?:	Former Smoker?_____	_____Yes ______No
If yes, When:	Quit Date:_____________	**FEMALES ONLY** Date of last Menses:
How?		Current Birth Control:

SURGERIES/ HOSPITALIZATIONS: List all and include date if known. Use the back of this form if more space is needed

FAMILY HISTORY: If any "blood" relative(s) have suffered any of the following. Match the NUMBER(S) of the medical condition with corresponding relative.

MEDICAL CONDITION #		Alive	Deceased	(circle Alive or Deceased for each family member)		
Mother:		Alive	Deceased 1.	1. Diabetes	6. Cancer	11. Asthma
Father:		Alive	Deceased 2.	2. Hypertension	7. Unknown	12. Hepatitis
Sister/Brother:		Alive	Deceased 3.	3. Heart Disease	8. Alcoholism	13. Osteoarthritis
Grandparents:		Alive	Deceased 4.	4. Stroke	9. Thyroid	
Aunt/Uncles:		Alive	Deceased	5. Mental Illness	10. Arthritis	

SYMPTOMS: Please mark a "C" for current problem, or your age at the time of the problem. Leave unmarked if no problem (s).

	PSYCHOLOGICAL		**EYE | EAR | NOSE | THROAT**		**GASTROINTESTINAL**		**CARDIOVASCULAR**
	Sleeping/concentration		Decreased hearing		Loss of appetite		Chest pain/Angina
	Nervousness/anxiety		Ringing in Ears		Difficulty swallowing		Irregular pulse
	Memory loss		Frequent Ear infections		Heartburn		Palpitations
	Feeling of worthlessness		____Dizzy spells ____Fainting		Persistent nausea		Swollen Ankles
	Phobia		Failing Vision		Abdominal pain		Calf pain
	Suicidal:		Nose Bleeds (recurrent)		Jaundice		Phlebitis
	Currently?		Sinus Trouble		__Diarrhea __Constipation		Varicose veins
	When:?		Sore Throats (frequent)		Diverticulitis/Colitis		**NEUROLOGICAL**
	How:?		Prolonged hoarseness		Bloody or Tarry stool		Headaches (frequent)
	DERMATOLOGY/ENDOCRINE		**RESPIRATORY**		**URINARY/GYNECOLOGICAL**		Numbness/tingling
	Eczema		Allergies/Hay Fever		Urinate more than2x per night		Tremors/hand shaking
	Psoriasis		Shortness of breath		Urgency/Frequency		Weakness
	____Rashes _____Hives		Chronic cough		Decreased stream		Seizures/stroke
	Tattoos/Body piercing		**MUSCULOSKELETAL**		Frequent urinary infections		
			Back pain (recurrent)		Blood in Urine		
			Joint pain		Pain Urinating		
			Leg pain when walking				
			Bone fractures/joint injury				Revised 3/2015