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

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. Hypertension	7. Unknown	12. Hepatitis
Sister/Brother:		Alive	Deceased	3. Heart Disease	8. Alcoholism	13. Osteoarthritis
Grandparents:		Alive	Deceased	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).

	SOCIAL HISTORY		**EYE | EAR | NOSE | THROAT**		**GASTROINTESTINAL**		**CARDIOVASCULAR**
	Smoke: ___yes ___no		Decreased hearing		Loss of appetite		Chest pain/Angina
	Former smoker: ____		Ringing in Ears		Difficulty swallowing		Irregular pulse
	Quit date:__________		Frequent Ear infections		Heartburn		Palpitations
	STREET DRUG USE		____Dizzy spells _____Fainting		Persistent nausea		Swollen Ankles
	____yes ___no		Failing Vision		Abdominal pain		Calf pain
	Type:______________		Nose Bleeds (recurrent)		Jaundice		Phlebitis
	ALCOHOL USE		Sinus Trouble		_____Diarrhea __Constipation		Varicose veins
	Daily: ____yes____no		Sore Throats (frequent)		Diverticulitis/Colitis		**DERMATOLOGY/ENDOCRINE**
	______oz. per day		Prolonged hoarseness		Bloody or Tarry stool		Eczema
	COFFEE/CAFFEINE		**RESPIRATORY**		**NEUROLOGICAL**		Psoriasis
	_____cups per day		Allergies/Hay Fever		Headaches (frequent)		____Rashes _____Hives
	SLEEPING AT NIGHT		Shortness of breath		Numbness/tingling		Tattoos/Body piercing
	____yes _____no		Chronic cough		Tremors/hand shaking		**PSYCHOLOGICAL**
	EXERCISE		**URINARY/GYNECOLOGICAL**		Weakness		Sleeping/concentration
	______x per week		Urinate more than 2x per night		Seizures/stroke		Nervousness/anxiety
	FEMALES ONLY		Urgency/Frequency		**MUSCULOSKELETAL**		Suicidal
	Date of last Menses:		Decreased stream		Back pain (recurrent)		Memory loss
	_________________		Frequent urinary infections		Bone fractures/joint injury		Feeling of worthlessness
	Current birth control:		Blood in Urine		Joint pain		Phobia
	Type:____________		Pain Urinating		Leg pain when walking		
							Revised 7/2014