

HEALTH QUESTIONNAIRE

Name _____	Date _____	Date of Birth _____	Sex: Male / Female
------------	------------	---------------------	--------------------

PLEASE check all recent or active medical problems

<p>SKIN</p> <input type="checkbox"/> Psoriasis <input type="checkbox"/> Hives <input type="checkbox"/> Acne <input type="checkbox"/> Moles <input type="checkbox"/> Rash <input type="checkbox"/> Dry Skin	<p>RESPIRATORY</p> <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing <input type="checkbox"/> Coughing Blood <input type="checkbox"/> Sputum Daily <input type="checkbox"/> Asthma <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Pneumonia	<p>MOOD DISORDERS</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Sleeping Problems <input type="checkbox"/> Stress <input type="checkbox"/> Family Problems <input type="checkbox"/> Marital Problems <input type="checkbox"/> Depression	<p>PAST MEDICAL HISTORY OR OTHER DISEASES</p> <input type="checkbox"/> Valvular Disease <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Gout <input type="checkbox"/> Cataracts <input type="checkbox"/> Fractures <input type="checkbox"/> Birth Defects <input type="checkbox"/> Liver Problems <input type="checkbox"/> Headaches <input type="checkbox"/> Drug/Alcohol Use (in recovery) <input type="checkbox"/> IV Drug Use (past / current) <input type="checkbox"/> Unprotected Sex (past / current) <input type="checkbox"/> Diabetes since age: _____ <input type="checkbox"/> Stroke
<p>HEAD</p> <input type="checkbox"/> Sinusitis <input type="checkbox"/> Stuffy Nose <input type="checkbox"/> Itchy Eyes <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Ear Pain <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures	<p>URINARY</p> <input type="checkbox"/> Frequency <input type="checkbox"/> Burning <input type="checkbox"/> Frequent Infection <input type="checkbox"/> Urinating at Night <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Sexual Problems <input type="checkbox"/> Discharge	<p>NUTRITION</p> <input type="checkbox"/> Weight Loss(unexplained) <input type="checkbox"/> Weight Gain <input type="checkbox"/> Special Diet	<p>CHILDHOOD ILLNESS</p> <input type="checkbox"/> Cancer of: _____ <input type="checkbox"/> Seizures <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Special Nutritional Needs <input type="checkbox"/> Hypertension Since Age: _____ <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Heart Attack at Age: _____ <input type="checkbox"/> Asthma Began at age: _____ <input type="checkbox"/> Gynecological Problems <input type="checkbox"/> Menopausal
<p>HEART</p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Swelling Legs <input type="checkbox"/> Palpitations	<p>MUSCLE/BONE</p> <input type="checkbox"/> Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Neck Pain <input type="checkbox"/> Difficulty Walking <input type="checkbox"/> Arthritis <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness		
<p>DIGESTIVE</p> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Cramping <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Liver Problems <input type="checkbox"/> GI Reflux	<p>SENSORY ORGANS</p> <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Vision Problems <input type="checkbox"/> Dizziness		
<p>SEXUAL HISTORY</p> <input type="checkbox"/> Sexually Active <input type="checkbox"/> Sexual Problems	<p>ENDOCRINE FUNCTION</p> <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Other Endocrine Problems		
<p>HISTORY OF:</p> <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes <input type="checkbox"/> Warts <input type="checkbox"/> Other _____			

Family History - List Illnesses and/or Cause of Death

Father: _____ Brothers: _____ Sons: _____
 Mother: _____ Sisters: _____ Daughters: _____

Your Surgeries or Hospitalizations	YEAR

FEMALES

Last PAP _____ Last Period _____ Implants Yes No
 Current Method of Birth Control _____

TOBACCO USE: None Cigarettes Cigars Pipes
 Smokeless Tobacco How much? _____

Did you get a flu shot last year? (Yes / No)
 Have you received a tetanus shot? (Yes / No) When? _____
 Do you wear a seatbelt every time you ride in a car? (Yes / No)
 What exercise do you do regularly? _____
 How many times per week? _____

Telephone numbers for contacting you

Day: _____
 Eve: _____
 Is it okay to leave a message? (Yes / No)