

HEALTH QUESTIONNAIRE

NAME _____ AGE _____ DATE _____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had

Childhood

Measles.....	No	Yes	Rheumatic fever or heart disease.....	No	Yes
Mumps.....	No	Yes	Tuberculosis.....	No	Yes
Chickenpox.....	No	Yes	Venereal disease.....	No	Yes
Diabetes.....	No	Yes	Congenital Abnormalities.....	No	Yes
Strokes.....	No	Yes	Other serious diseases.....	No	Yes
Cancer.....	No	Yes			

Adult:

Have you had a serious illness?..... No Yes

Have you ever been hospitalized or been under medical care for very long?..... No Yes

If yes, for what reason?.....

Operations:

Have you had any surgery?..... No Yes

Injuries:

Have you had any broken bones?..... No Yes

Have you had any head concussions or injuries?..... No Yes

Have you ever been knocked unconscious?..... No Yes

FAMILY HISTORY:	If Living:		If Deceased	Has any blood relative ever had?			
	Age	Health		Age (at death) & Cause		Yes	Who
Father				Cancer	Yes	Who	What type
Mother				Tuberculosis	Yes	Who	What type
Brother/Sister				Diabetes	Yes	Who	What type
				Heart Trouble	Yes	Who	What type
				High Blood Pressure	Yes	Who	What type
Husband/Wife				Stroke	Yes	Who	What type
Son/Daughter				Convulsions	Yes	Who	What type
				Suicide	Yes	Who	What type
				Insanity	Yes	Who	What type
				Bleeding tendency	Yes	Who	What type
				Gout or other arthritis	Yes	Who	What type

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed

Are you living with your husband or wife?..... No Yes

Is your sex life satisfactory?..... No Yes

Do you have dependents at home?..... No Yes

Alcoholic Beverages: ___Never ___Rarely ___Moderately ___Daily ___Ever..... No Yes

Tobacco: ___Cigarettes ___Packs a day ___Don't Smoke ___Ever Smoked..... No Yes

Are you employed? ___Full time ___Part time

What is your job?.....

Are you exposed to fumes, dust or solvents?.....

Education

Grade School	(Years) _____
High School	_____
College	_____
Postgraduate	_____

How much time have you lost from work because of your health during the past?

Six Month _____

One Year _____

Five Years _____

SYSTEMIC REVIEW: Do you have any of the following?

General:

Recent weight change..... No Yes

Have you been in good general health most of your life No Yes

Skin:

Skin Disease..... No Yes

Jaundice..... No Yes

Hives, eczema or rash..... No Yes

Frequent infection or boils..... No Yes

Abnormal pigmentation..... No Yes

Head-Eyes-Ears-Nose-Throat

Eye disease or injury..... No Yes

Do you wear glasses?..... No Yes

Double vision..... No Yes

Headaches..... No Yes

Glaucoma..... No Yes

Itching eyes or nose..... No Yes

Head-Eyes-Ears-Nose-Throat (cont'd)

Sneezing or runny nose..... No Yes

Nose Bleeds..... No Yes

Chronic sinus trouble..... No Yes

Ear Disease..... No Yes

Impaired Hearing..... No Yes

Dizziness or transient episodes or unconsciousness..... No Yes

Neck:

Stiffness..... No Yes

Thyroid trouble..... No Yes

Enlarged glands..... No Yes

Respiratory

URI (cold) now..... No Yes

Spitting up blood..... No Yes

Chronic or frequent cough..... No Yes

SYSTEMIC REVIEW:

Respiratory Cont'd

Asthma or Wheezing No Yes
 Difficulty breathing No Yes
 Any trouble with lungs No Yes
 Pleurisy or Pneumonia No Yes

Cardiovascular:

Chest pain or angina pectoris No Yes
 Shortness of breath with walking or lying down No Yes
 Difficulty walking two blocks No Yes
 Heart Trouble or heart attacks No Yes
 High blood pressure No Yes
 Swelling of hands, feet or ankles No Yes
 Awakening in the night smothering No Yes
 Heart murmur No Yes

Gastrointestinal:

Peptic Ulcer (stomach or duodenal) No Yes
 Vomiting blood or food No Yes
 Gallbladder disease No Yes
 Liver trouble No Yes
 Hepatitis No Yes
 Painful bowel movements No Yes
 Bleeding with bowel movements No Yes
 Black stools No Yes
 Hemorrhoids or piles No Yes
 Recent change in bowel habits No Yes
 Frequent diarrhea No Yes
 Heartburn or indigestion No Yes
 Cramping or pain in the abdomen No Yes
 Does food stick in throat No Yes

Genitourinary:

Loss of urine No Yes
 Frequent urination No Yes
 Night time urination No Yes
 Burning or painful urination No Yes
 Blood in urine No Yes
 Kidney trouble No Yes
 Kidney stones No Yes

Gynecological:

Age periods started _____
 How long do periods last? _____ Days

Gynecological (Cont'd)

Number of pregnancies No Yes
 Number of miscarriages No Yes
 Date of last cancer smear and results _____

Frequency of periods, every _____ days.
 Any pain with your periods No Yes
 Number of children _____ Ages _____
 Date of first day of last period _____

Locomotor-Musculoskeletal:

Varicose Veins No Yes
 Weakness of muscles or joints No Yes
 Any difficulty in walking No Yes
 Any pain in calves or buttocks on walking
 relieved by rest No Yes

Neuro-Psychiatric:

Have you ever had psychiatric care? No Yes
 Have you been advised to see a psychiatrist? No Yes
 Do you ever have, or have had, fainting spells? No Yes
 Convulsions No Yes
 Paralysis No Yes

Hematologic:

Are you slow to heal after cuts No Yes
 Blood disease No Yes
 Anemia No Yes
 Phlebitis No Yes
 Have you had difficulty with bleeding excessively
 after tooth extraction or surgery? No Yes
 Have you had abnormal bruising or bleeding? No Yes

Allergic:

Any allergies, including medication No Yes

Endocrine:

Thyroid disease No Yes
 Hormone therapy No Yes
 Any change in hat or glove size No Yes
 Any change in hair growth No Yes
 Have you become colder than before-
 or skin become drier No Yes

HEIGHT _____
 WEIGHT _____
 Date of last tetanus _____

ALLERGIES AND SENSITIVITIES

1. Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of:

	Circle One		What Drug or Food?
Penicillin or other antibiotics Yes	No	Don't know	_____
Morphine, Codeine, Demerol or other narcotics Yes	No	Don't know	_____
Aspirin, emiprin or other pain remedies Yes	No	Don't know	_____
Sulfa drugs Yes	No	Don't know	_____
Tetanus antitoxin or other serums Yes	No	Don't know	_____
Adhesive tape Yes	No	Don't know	_____
Iodine or merthiolate Yes	No	Don't know	_____
Any other drug or medication Yes	No	Don't know	_____
Any foods, such as egg, milk or chocolate Yes	No	Don't know	_____

2. Drugs Recently Taken: Within the past six months has patient taken

Cortisone Yes	No	Don't know
ACTH Yes	No	Don't know
Anticoagulants Yes	No	Don't know
Tranquilizers Yes	No	Don't know
Hypotensives (high blood pressure medicines) Yes	No	Don't know
Has the patient ever received treatment for:		
Asthma, rheumatism or rheumatic fever? Yes	No	Don't know
Aspirin Yes	No	Don't know

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Doctor: _____

Date: _____

Signature of Patient: _____