HEALTH QUESTIONNAIRE

NAME _____ AGE _____ DATE _____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had

Childhood:

Measles	No	Yes	Rheumatic fever of 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 any 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

List _____ _____

_____ _____

_____ _____

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: Age	If Living: Health	If Deceased: Age (at death) & Cause		Has any blood relative ever had:		
Father					Cancer	No	Yes
Mother					Tuberculosis	No	Yes
Brother/Sister					Diabetes	No	Yes
					Heart Trouble	No	Yes
					High blood pressure	No	Yes
Husband/Wife					Stroke	No	Yes
Son/Daughter					Convulsions	No	Yes
					Suicide	No	Yes
					Insanity	No	Yes
					Bleeding tendency	No	Yes
					Gout or other arthritis	No	Yes

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, dusts or solvents? _____

Education: (Years)

Grade School _____

High School _____

College _____

Postgraduate _____

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

Six Months _____

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

Nosebleeds ..... No Yes

Chronic sinus trouble ..... No Yes

Ear disease ..... No Yes

Impaired hearing ..... No Yes

Dizziness or transient episodes ..... No Yes

of 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

YSTEMIC 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
- 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
- Hemmorrhoids 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 urinaton ..... No Yes
- Blood in urine ..... No Yes
- Kidney trouble ..... No Yes
- Kidney stones ..... No Yes
- Bright's Disease ..... No Yes

Gynecological:
- Age periods started _____
- How long do periods last? _____ Days

Gynecological (cont'd)
- Number of pregnancies _____
- Number of miscarriages _____
- Date of last cancer smear and results _____
- _____
- Frequency of periods, every _____ days
- Any pain with your periods ..... No Yes
- Number of childern _____ 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

Hemotologic:
- 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 dryer ..... No Yes

HEIGHT _____

WEIGHT _____

ALLERGIES AND SENSITIVITIES

. 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 anitbiotic	Yes	No	Don't know	_____
Morphine, Codeine, Demerol or other narcotics	Yes	No	Don't know	_____
Novocain or other anesthetics	Yes	No	Don't know	_____
Aspirin, empirin 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	_____

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

Cotisone	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

ource of information, if other than patient: _____

ignature of person acquiring this information: _____

octor Date S I'Nature of patient