

Health Questionnaire

Patient: _____ DOB: _____ Age: _____ Date: _____

Reason for Visit: _____

Medications:

Please list the name and strength of the medications you are currently taking. (For example, Digoxin 0.125 mg.)

Name	Strength (e.g., 10 mg.)	Name	Strength

Drug Allergies:

Please list any drug allergies, including reactions. Please state NONE if no allergies.

Drug	Reaction	Drug	Reaction

Non-Drug Allergies:

Please list any food or non-drug allergies, including reactions. State NONE if no allergies. (For example, Latex, mold, milk, nuts, etc.)

Substance	Reaction	Substance	Reaction

Past Illnesses

Please circle Y or N if you have had any illnesses in the past.

- | | | | | | | | | | | | |
|------------|---|---|------------------------|---|---|---------------------|---|---|--------------|---|---|
| Anemia | Y | N | Chronic fatigue | Y | N | Hay Fever/Allergies | Y | N | Pneumonia | Y | N |
| Arthritis | Y | N | Coronary heart disease | Y | N | Heart murmur | Y | N | Peptic ulcer | Y | N |
| Anxiety | Y | N | Depression | Y | N | Hepatitis | Y | N | Psoriasis | Y | N |
| Asthma | Y | N | Diabetes I | Y | N | Hypertension | Y | N | Seizures | Y | N |
| Bone | Y | N | Diabetes II | Y | N | Kidney stones | Y | N | Stroke | Y | N |
| Bronchitis | Y | N | Eczema | Y | N | Memory Loss | Y | N | TB | Y | N |
| Cataract | Y | N | Glaucoma | Y | N | Osteoporosis | Y | N | Thyroid | Y | N |
| Cancer | Y | N | | | | | | | | | |

Please describe type of cancer and treatment you have received. (For example, radiation, chemotherapy, surgery)

- | | | | | | | | | | | | | | | |
|-------------|---|---|---------|---|---|-------|---|---|---------------|---|---|-----------------|---|---|
| Chicken Pox | Y | N | Measles | Y | N | Mumps | Y | N | Scarlet fever | Y | N | Rheumatic fever | Y | N |
|-------------|---|---|---------|---|---|-------|---|---|---------------|---|---|-----------------|---|---|

Previous Surgeries

Please list name and date of any past surgeries.

Surgery	Year

Height: _____

Weight: _____ Lbs

Family History Please circle if any blood relative has suffered any of the following:

- | | | | | | | |
|--------------|------------|--------------------------|-----------|-----------------|-----------------|------------------|
| Alcoholism | Anemia | Anesthesia complications | Arthritis | Asthma | Bleeding easily | Blindnes |
| Cancer | Crib death | Diabetes | Hay fever | Hearing Loss | Heart disease | High cholesterol |
| Hypertension | Migraines | Renal (kidney) disease | Stroke | Thyroid disease | | |

Social History Please circle appropriate response:

- Use of alcohol:** Never Occasional/Social Moderate Daily
- Use of tobacco:** Never Previously, but quit in _____ Daily Packs/Day _____
- Is there a history of exposure to second hand smoke?** Y N
- Use of recreational drugs:** Never Previously, but quit in _____ Active use _____
- Is there a history of exposure to excessive noise?** Y N Military Work Hobbies

Review of systems Please circle Y or N if you have had any of these symptoms.

Constitution	ENT	Cardiovascular
Appetite Loss..... Y N	Ear ache/pain..... Y N	Chest pain..... Y N
Bad breath/taste..... Y N	Ear drainage..... Y N	Swelling of ankles..... Y N
Chills..... Y N	Ear infection..... Y N	Heart palpitations..... Y N
Fatigue..... Y N	Ringing in ears..... Y N	Psychiatric
Fever..... Y N	Nose bleeds..... Y N	Depression..... Y N
Difficulty sleeping..... Y N	Sinus problems..... Y N	Anxiety..... Y N
Daytime sleepiness..... Y N	Sore throats..... Y N	Memory Loss..... Y N
Weight Loss-recent..... Y N	Snoring..... Y N	Gastroenterology
	Difficulty swallowing..... Y N	Abdominal pain..... Y N
	Prolonged hoarseness..... Y N	Bloody stools..... Y N
Other	Decreased hearing..... Y N	Constipation..... Y N
Night sweats..... Y N	Decreased smell..... Y N	Diarrhea..... Y N
Travel out of U.S..... Y N	Ear pulling..... Y N	Heartburn..... Y N
Head banging..... Y N		Persistent Nausea..... Y N
Fussy/Irritable..... Y N	Respiratory	Persistent vomiting..... Y N
Speech/Language Difficulty..... Y N	Cough, chronic..... Y N	Skin
	Shortness of breath..... Y N	Rash..... Y N
Eyes	On exertion..... Y N	Hematology
Double vision..... Y N	Lying flat..... Y N	Easy..... Y N
Blurred vision..... Y N	Coughing Blood..... Y N	Transfusion history..... Y N
Failing vision..... Y N	Neurology	
Eye pain..... Y N	Headaches..... Y N	Genitourinary
	Dizzy spells..... Y N	Blood in..... Y N
Musculoskeletal	Numbness/tingling..... Y N	Frequent urinary infections..... Y N
Muscle..... Y N	Fainting spells..... Y N	