# Health Questionnaire

Name: _____ Date: _____ DOB: _____

**Chief Complaint**: _____

**Brief History of Problem**: _____

_____

_____

**Past Medical History**: (Please check if applicable)

___ High Blood Pressure ___ Diabetes ___ Stroke ___ Heart Problems ___ Lung Problems

___ Glaucoma ___ Cancer ___ Anemia ___ Liver disease ___ Blood Clots

___ Epilepsy ___ Gastrointestinal ___ Gynecological Problems

Other: _____

_____

**Surgical History**: _____

_____

**Habits**:

Alcohol _____ # drinks/week Cigarettes _____ # cig/day x _____ # years _____ year quit

Other tobacco usage: _____ Current frequency: _____

Caffeine _____ # cups/day Recreational Drugs: _____

**Women Only**:

Date of last PAP Test _____ Normal? _____ Abnormal? _____

Date of last mammogram _____ Normal? _____ Abnormal? _____

Date of last period (1st day) _____ Menopausal symptoms? _____

Irregular periods? _____ Menstrual pain? _____

Pre-menstrual complaints? _____

History of Pregnancies: _____

**Family History**:

_____ Migraine _____High Blood Pressure _____ Cancer

_____ Epilepsy _____ Diabetes _____ Anemia

_____Cerebral Aneurysm _____ Stroke _____ Liver Disease

_____Multiple Sclerosis _____ Heart Problems _____ Blood Clots

_____Parkinsons _____ Lung Problems _____ Osteoporosis

_____Alzheimer/Dementia _____ Glaucoma

Other: _____

**Allergies**: _____

_____

Name: _____ Date: _____ DOB: _____

**Current Medications**:

| Medication | Dosage | Action |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Review of Current/Recent Symptoms**: (check all that are applicable)

General: ___ Fever ___ Chills ___ Weight Loss ___ Weakness

Skin: ___ Rash ___ Itching

Hematopoietic: ___ Bruising ___ Bleeding ___ Anemia

HEENT: ___ Vision changes ___ Double vision ___ Glaucoma ___ Hearing problems
___ Vertigo

Respiratory: ___ Cough ___ Coughing Blood ___ Shortness of Breath ___ Infections

Cardiovascular: ___ Chest Pain ___ Murmurs ___ Pain in legs with walking ___ Swelling in the legs

Gastro-Intestinal: ___ Constipation ___ Diarrhea ___ Bleeding ___ Hemorrhoids ___ Indigestion
___ Hepatitis

Genito-Urinary: ___ Burning ___ Bleeding leaking (incontinence) ___ Flank pain ___ Loss of erections

Muscle-skeletal: ___ Joint Pain ___ Weakness ___ Back pain ___ Cramps

Neurologic: ___ Headache ___ Dizziness ___ Seizures ___ Blackouts ___ Depression
___ Sleeping problems
Other:_____
_____

Other Comments:_____
_____

_____ _____
Signature Date