HEALTH QUESTIONNAIRE

Please complete this questionnaire so that we can serve your health care needs. NOTE: This is the confidential information that will not be released to any person except when you have authorized us to do so. Please use the back side if you need more space.

Name: | **Age:** **Date of Birth**: | O Single O Divorced O Married O Widowed

Date of last Physical Exam: | **Birthplace:** | **Today's Date:**

Occupation:

List all medications, dose and frequency presently being taken (including birth control pills and vitamins)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Past Surgies/Hospilizations (give details- dates and reasons):

Last date of Tetanus:

Allergies (circle if allergic to any of the following)
Penicillin Bees/Wasps Other _____
Sulfa Codeine/Morphine Reaction:
Mycin Tetanus antitoxins
Aspirin Foods

Comments:

What kind of special diet do you follow?

Past Medical History/ Review of Systems

O Aids/HIV Disease
O Anemia or any bleeding disorder
O Any bone or Joint Disease
O Appendicitis
O Arthritis or Rheumatism
O Asthma
O Bladder disease or and Urinary Tract Disease
O Broken or Cracked Bones
O Bronchitis
O Bursitis, Siatica or Lumbago
O Cancer
O Chicken Pox
O Colitis or bowel disease
O Concussion
O Diabetes
O Diphtheria
O Dislocations
O Emphysema
O Epilepsy/ Seizures
O Food, Chemical or Drug Poisoning
O Frequent Infections or Boils
O Gallbladder Disease
O German Measles
O Glaucoma/ Cataracts
O Gonorrhea, Syphilis, Chlamydia or any other sexually transmitted disease
O Gout
O Hay Fever
O Heart Disease
O Hemorrhoids or any rectal disease
O Hepatitis or Jaundice
O High or Low Blood Pressure
O Hives or Eczema
O Influenza (flu)
O Lacerations
O Measles
O Migraine Headaches
O Mumps
O Nephritis or any other Kidney Disease
O Nervous Disorder or any other Psychiatric Disorder
O Neuritis or Neuralgia
O Pleurisy
O Pneumonia
O Polio or Meningitis
O Rheumatic Fever or Heart Disease
O Scarlet Fever or Scarlatina
O Skin Diseases
_____
O Small Pox
O Sprains/ Spasms
O Whooping Cough
O Tuberculosis
O Other Diseases
_____

Social History (please circle appropriate answer):
Have you ever smoked? Yes No
How many packs per day: _____
For how many years? _____

Do you drink alcohol? Yes No
If so how much per day? _____

Have you ever taken recreational drugs? (ie. Pot, cocaine, crack, etc) Yes No

Are you sexually active? Yes No
Type of Birth Control used? _____

Have you ever been abused? Yes No
If yes, when? _____

For Women Only:
How old were you when your periods started? _____
How many Pregnancies? _____
Miscarriages? ____ Abortions? _____
Date of your last period? _____
Date of last pap smear? _____
Date of last mammogram? _____
Who is your Gynecologist? _____

Family History: Has anyone in your family (blood relatives) had any of these conditions?

O Alcoholism O Bowel Problems O Epilepsy/Seizures O High Blood Pressure O Lung Problems O Psychiatric Problems
O Stroke O Arthritis O Cancer O Heart Problems O Obesity O Kidney Problems
O Diabetes O Skin Problems O Tuberculosis O Bleeding Problems

	Name	Age	Living Medical Problems	Deceased Cause of Death
Mother				
Father				
Siblings				
Spouse				
Children				