

## 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.

<b>Name:</b>	<b>Age:</b>	<b>Date of Birth:</b>	<input type="radio"/> Single	<input type="radio"/> Divorced
			<input type="radio"/> Married	<input type="radio"/> Widowed

<b>Date of last Physical Exam:</b>	<b>Birthplace:</b>	<b>Today's Date:</b>
------------------------------------	--------------------	----------------------

<b>Occupation:</b>	<b>Past Surgeries/Hospitalizations (give details- dates and reasons):</b>
--------------------	---

<b>List all medications, dose and frequency presently being taken (including birth control pills and vitamins)</b> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____	<b>Last date of Tetanus:</b> _____ <b>Allergies (circle if allergic to any of the following)</b> Penicillin Bees/Wasps Other _____ Sulfa Codeine/Morphine Reaction: _____ Mycin Tetanus antitoxins _____ Aspirin Foods _____
--	---

<b>What kind of special diet do you follow?</b>	<b>Comments:</b>
---	------------------

<b>Past Medical History/ Review of Systems</b> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"> <input type="radio"/> Aids/HIV Disease  <input type="radio"/> Anemia or any bleeding disorder  <input type="radio"/> Any bone or Joint Disease  <input type="radio"/> Appendicitis  <input type="radio"/> Arthritis or Rheumatism  <input type="radio"/> Asthma  <input type="radio"/> Bladder disease or and Urinary Tract Disease  <input type="radio"/> Broken or Cracked Bones  <input type="radio"/> Bronchitis  <input type="radio"/> Bursitis, Siatica or Lumbago  <input type="radio"/> Cancer  <input type="radio"/> Chicken Pox  <input type="radio"/> Colitis or bowel disease  <input type="radio"/> Concussion  <input type="radio"/> Diabetes  <input type="radio"/> Diphtheria           </td> <td style="width: 33%; border: none;"> <input type="radio"/> Dislocations  <input type="radio"/> Emphysema  <input type="radio"/> Epilepsy/ Seizures  <input type="radio"/> Food, Chemical or Drug Poisoning  <input type="radio"/> Frequent Infections or Boils  <input type="radio"/> Gallbladder Disease  <input type="radio"/> German Measles  <input type="radio"/> Glaucoma/ Cataracts  <input type="radio"/> Gonorrhea, Syphilis, Chlamydia or any other sexually transmitted disease  <input type="radio"/> Gout  <input type="radio"/> Hay Fever  <input type="radio"/> Heart Disease  <input type="radio"/> Hemorrhoids or any rectal disease  <input type="radio"/> Hepatitis or Jaundice  <input type="radio"/> High or Low Blood Pressure  <input type="radio"/> Hives or Eczema           </td> <td style="width: 33%; border: none;"> <input type="radio"/> Influenza (flu)  <input type="radio"/> Lacerations  <input type="radio"/> Measles  <input type="radio"/> Migraine Headaches  <input type="radio"/> Mumps  <input type="radio"/> Nephritis or any other Kidney Disease  <input type="radio"/> Nervous Disorder or any other Psychiatric Disorder  <input type="radio"/> Neuritis or Neuralgia  <input type="radio"/> Pleurisy  <input type="radio"/> Pneumonia  <input type="radio"/> Polio or Meningitis  <input type="radio"/> Rheumatic Fever or Heart Disease  <input type="radio"/> Scarlet Fever or Scarlatina  <input type="radio"/> Skin Diseases    <input type="radio"/> Small Pox  <input type="radio"/> Sprains/ Spasms  <input type="radio"/> Whooping Cough  <input type="radio"/> Tuberculosis  <input type="radio"/> Other Diseases           </td> </tr> </table>	<input type="radio"/> Aids/HIV Disease <input type="radio"/> Anemia or any bleeding disorder <input type="radio"/> Any bone or Joint Disease <input type="radio"/> Appendicitis <input type="radio"/> Arthritis or Rheumatism <input type="radio"/> Asthma <input type="radio"/> Bladder disease or and Urinary Tract Disease <input type="radio"/> Broken or Cracked Bones <input type="radio"/> Bronchitis <input type="radio"/> Bursitis, Siatica or Lumbago <input type="radio"/> Cancer <input type="radio"/> Chicken Pox <input type="radio"/> Colitis or bowel disease <input type="radio"/> Concussion <input type="radio"/> Diabetes <input type="radio"/> Diphtheria	<input type="radio"/> Dislocations <input type="radio"/> Emphysema <input type="radio"/> Epilepsy/ Seizures <input type="radio"/> Food, Chemical or Drug Poisoning <input type="radio"/> Frequent Infections or Boils <input type="radio"/> Gallbladder Disease <input type="radio"/> German Measles <input type="radio"/> Glaucoma/ Cataracts <input type="radio"/> Gonorrhea, Syphilis, Chlamydia or any other sexually transmitted disease <input type="radio"/> Gout <input type="radio"/> Hay Fever <input type="radio"/> Heart Disease <input type="radio"/> Hemorrhoids or any rectal disease <input type="radio"/> Hepatitis or Jaundice <input type="radio"/> High or Low Blood Pressure <input type="radio"/> Hives or Eczema	<input type="radio"/> Influenza (flu) <input type="radio"/> Lacerations <input type="radio"/> Measles <input type="radio"/> Migraine Headaches <input type="radio"/> Mumps <input type="radio"/> Nephritis or any other Kidney Disease <input type="radio"/> Nervous Disorder or any other Psychiatric Disorder <input type="radio"/> Neuritis or Neuralgia <input type="radio"/> Pleurisy <input type="radio"/> Pneumonia <input type="radio"/> Polio or Meningitis <input type="radio"/> Rheumatic Fever or Heart Disease <input type="radio"/> Scarlet Fever or Scarlatina <input type="radio"/> Skin Diseases  <input type="radio"/> Small Pox <input type="radio"/> Sprains/ Spasms <input type="radio"/> Whooping Cough <input type="radio"/> Tuberculosis <input type="radio"/> Other Diseases	<b>Social History (please circle appropriate answer):</b> 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? _____  <b>For Women Only:</b> 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? _____
<input type="radio"/> Aids/HIV Disease <input type="radio"/> Anemia or any bleeding disorder <input type="radio"/> Any bone or Joint Disease <input type="radio"/> Appendicitis <input type="radio"/> Arthritis or Rheumatism <input type="radio"/> Asthma <input type="radio"/> Bladder disease or and Urinary Tract Disease <input type="radio"/> Broken or Cracked Bones <input type="radio"/> Bronchitis <input type="radio"/> Bursitis, Siatica or Lumbago <input type="radio"/> Cancer <input type="radio"/> Chicken Pox <input type="radio"/> Colitis or bowel disease <input type="radio"/> Concussion <input type="radio"/> Diabetes <input type="radio"/> Diphtheria	<input type="radio"/> Dislocations <input type="radio"/> Emphysema <input type="radio"/> Epilepsy/ Seizures <input type="radio"/> Food, Chemical or Drug Poisoning <input type="radio"/> Frequent Infections or Boils <input type="radio"/> Gallbladder Disease <input type="radio"/> German Measles <input type="radio"/> Glaucoma/ Cataracts <input type="radio"/> Gonorrhea, Syphilis, Chlamydia or any other sexually transmitted disease <input type="radio"/> Gout <input type="radio"/> Hay Fever <input type="radio"/> Heart Disease <input type="radio"/> Hemorrhoids or any rectal disease <input type="radio"/> Hepatitis or Jaundice <input type="radio"/> High or Low Blood Pressure <input type="radio"/> Hives or Eczema	<input type="radio"/> Influenza (flu) <input type="radio"/> Lacerations <input type="radio"/> Measles <input type="radio"/> Migraine Headaches <input type="radio"/> Mumps <input type="radio"/> Nephritis or any other Kidney Disease <input type="radio"/> Nervous Disorder or any other Psychiatric Disorder <input type="radio"/> Neuritis or Neuralgia <input type="radio"/> Pleurisy <input type="radio"/> Pneumonia <input type="radio"/> Polio or Meningitis <input type="radio"/> Rheumatic Fever or Heart Disease <input type="radio"/> Scarlet Fever or Scarlatina <input type="radio"/> Skin Diseases  <input type="radio"/> Small Pox <input type="radio"/> Sprains/ Spasms <input type="radio"/> Whooping Cough <input type="radio"/> Tuberculosis <input type="radio"/> Other Diseases		

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

<input type="radio"/> Alcoholism	<input type="radio"/> Bowel Problems	<input type="radio"/> Epilepsy/Seizures	<input type="radio"/> High Blood Pressure	<input type="radio"/> Lung Problems	<input type="radio"/> Psychiatric Problems
<input type="radio"/> Stroke	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> Heart Problems	<input type="radio"/> Obesity	<input type="radio"/> Kidney Problems
<input type="radio"/> Diabetes	<input type="radio"/> Skin Problems	<input type="radio"/> Tuberculosis	<input type="radio"/> Bleeding Problems		

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