

HEALTH QUESTIONNAIRE

NAME _____ AGE _____ DATE _____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had

Childhood:

Measles No Yes	Rheumatic fever or heart disease No Yes
Mumps No Yes	Tuberculosis No Yes
Chickenpox No Yes	Veneral 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:		If Deceased:		Has any blood relative ever had:	
	Age	Health	Age (at death) & Cause			
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?

<p><u>General:</u></p> <p>Recent weight change? No Yes</p> <p>Have you been in good general health most of your life? No Yes</p> <p><u>Skin:</u></p> <p>Skin Disease No Yes</p> <p>Jaundice No Yes</p> <p>Hives, eczema or rash No Yes</p> <p>Frequent infection or boils No Yes</p> <p>Abnormal pigmentation No Yes</p> <p><u>Head-Eyes-Ears-Nose-Throat:</u></p> <p>Eye disease or injury No Yes</p> <p>Do you wear glasses? No Yes</p> <p>Double vision No Yes</p> <p>Headaches No Yes</p> <p>Glaucoma No Yes</p> <p>Itching eyes or nose No Yes</p>	<p><u>Head-Eyes-Ears-Nose-Throat (cont'd)</u></p> <p>Sneezing or runny nose No Yes</p> <p>Nosebleeds No Yes</p> <p>Chronic sinus trouble No Yes</p> <p>Ear disease No Yes</p> <p>Impaired hearing No Yes</p> <p>Dizziness or transient episodes of unconsciousness No Yes</p> <p><u>Neck:</u></p> <p>Stiffness No Yes</p> <p>Thyroid trouble No Yes</p> <p>Enlarged glands No Yes</p> <p><u>Respiratory:</u></p> <p>URI (cold) now No Yes</p> <p>Spitting up blood No Yes</p> <p>Chronic or frequent cough No Yes</p>
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SYSTEMIC 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
 High blood pressure 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
 Hemorrhoids 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 urinating No Yes
 Burning or painful urination 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 children _____ 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

Hematologic:

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

1. Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of:

	Yes	No	Circle One	What Drug or Food?
Penicillin or other antibiotics	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	_____

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

Cortisone	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

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Doctor _____ Date _____ Signature of patient _____