Health Questionnaire

Date:_____

Confidential record: Information contained here will not be released except when you have authorized us to do so.

Last Name_____ First Name_____
Address_____ City, State, Zip_____
Birthdate_____ Birth place_____
Home Phone_____ Cell Phone_____
Family or Referring Physician_____ Physician Office#_____
Physician Fax#_____ Physician Address_____

REASON FOR HEALTH VISIT:

What symptoms or medical problem are you seeing Doctor today for:

_____

MEDICAL PROBLEMS:

List all current medical problems and those that have required hospitalization in the past:

_____

SURGICAL HISTORY:

Please list all previous surgeries:

_____

MEDICATIONS: Please list **all** medications, dosages, and frequency of administration:

_____

_____

NAME ANY DRUGS TO WHICH YOU ARE ALLERGIC:_____

PERSONAL HISTORY:

Occupation:_____
Do you smoke?: Yes No. If so how much?:_____
Have you ever smoked? Yes No
How much alcohol do you drink?_____
Any history of recreational drug use? Yes No. If so which drugs?:_____

PLEASE CIRCLE IF YOU HAVE ANY OF THE BELOW SYMPTOMS:

Constitutional – fever, weight loss, weight gain, night sweats, nausea
Eyes – blurred vision, dry eyes, double vision, loss of vision, pain with eye movement
Cardiovascular – heart disease, chest pain, palpitations, swelling of the feet and legs
Respiratory – asthma, COPD, difficulty breathing, shortness of breath
Gastrointestinal – abdominal pain, diarrhea, constipation, bloody stools
Genitourinary – painful urination, blood in the urine, frequent urination, sexual dysfunction
Musculoskeletal – joint pain, muscle pain
Skin – rashes, bites
Neurological – seizures, headaches, dizziness, falls, numbness, tingling, back pain, neck pain, weakness, difficulty walking, stroke
Psychiatric – depression, anxiety, mood disorders, insomnia, hallucinations
Endocrine – intolerant to heat, cold, thyroid dysfunction
Hematologic – easy bruising, bleeding, history of blood transfusions
Allergy - seasonal or environmental allergies
Infectious - HIV, Hepatitis A B C

Patient Signature:_____ Date:_____
Reviewed by and title:_____ Date:_____