Health Questionnaire

Name_____ Date of Birth ____/____/____ Today's Date _____

Occupation _____ SS# _____-____-_____ Age _____

Married ____ Single ____Divorced ____ Widowed ____ Male ____ Female ____ Place of birth _____

Date of last exam _____ Last tetanus shot? _____ Who were you referred by? _____

Chief Complaint _____

*Do you have an Advanced Directive? Yes ____ No ____ [for office use only: Offered ____ DNR ____ CPR ____

Family History (Please check ALL that apply)

	Father	Mother	Paternal Grand Father	Paternal Grand Mother	Maternal Grand Father	Maternal Grand Mother	Paternal Uncle	Paternal Aunt	Maternal Uncle	Maternal Aunt	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drug Addiction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Current Meds (include OTC & Vitamins)

Name	Dose	Times/Day?	Name	Dose	Times/Day?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Drug Allergies Reaction

_____ _____
_____ _____
_____ _____

Hospitalization or Surgery

Reason	Date	Reason	Date

Immunization History:

Pneumonia Vaccine: ___ Yes ___ No Date: _____ Tetanus shot within 10 years: ___ Yes ___ No Date: _____

Continue on back

Medical History (please check ALL that apply & give date of onset or procedure)

☐ Hypertension_____	☐ Dizzy/Fatigue_____	☐ Ulcer _____
☐ High Cholesterol_____	☐ Anxiety/Depression_____	☐ Heartburn/GI Disorder _____
☐ Heart Palpitations _____	☐ Fatigue_____	☐ Sexual Problem_____
☐ Heart Murmur_____	☐ Shortness of Breath_____	☐ Menstrual Problems _____
☐ Irregular Heart Rate_____	☐ Foot Problem_____	☐ Bladder Problem_____
☐ Chest Pain/Angina _____	☐ Allergies/Hay fever_____	☐ Anemia_____
☐ Heart Attack _____	☐ Asthma _____	☐ Arthritis _____
☐ Stroke/TIAs_____	☐ COPD/Emphysema_____	☐ Osteoporosis_____
☐ Peripheral Vascular Disease _____	☐ Pneumonia_____	☐ Gout_____
☐ Congestive Heart Failure_____	☐ Sexually Transmitted Disease_____	☐ Diabetes_____
☐ Birth Defect of the Heart_____	☐ Scarlet Fever_____	☐ Thyroid/Endocrine Disease____
☐ Headaches_____	☐ Rheumatic Fever_____	☐ Cancer_____
☐ Alcoholism_____	☐ Sleeping Problem/Insomnia_____	☐ Transfusion_____

Personal Habits

Tobacco Products: Type & Amount daily _____ Interested in quitting? Yes ____ No ____

Have you ever used "recreational drugs"? Yes ____ No ___ if yes, what type: _____

Alcohol: Type & Amount daily _____ Coffee/Caffeine: Amount daily _____

Do you like your work? Yes ____ No ____ Hobbies/Sports: _____

Exercise routine: _____

Women only

Date of last period _____ Pregnancies/Live births: ____/____ Birth control method: _____

Planning pregnancy? Yes ___ No ___

Men only

Do you occasionally experience erection difficulties? Yes ____ No ____

Do you have any other concerns that are not listed above? _____

_____