

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 ____]

Drug Allergies

Family History (please check ALL that apply)

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Meds (Include OTC & Vitamins)

Continue on back if necessary

Hospitalization or Surgery

Reason	Date	Reason	Date

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Dizziness / Fainting _____ | <input type="checkbox"/> Ulcer _____ |
| <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Anxiety / Depression _____ | <input type="checkbox"/> Heartburn / GI Disorder _____ |
| <input type="checkbox"/> Heart Palpitations _____ | <input type="checkbox"/> Fatigue _____ | <input type="checkbox"/> Sexual Problem _____ |
| <input type="checkbox"/> Heart Murmur _____ | <input type="checkbox"/> Shortness of Breath _____ | <input type="checkbox"/> Menstrual Problem _____ |
| <input type="checkbox"/> Irregular Heart Rate _____ | <input type="checkbox"/> Foot Problem _____ | <input type="checkbox"/> Bladder Problem _____ |
| <input type="checkbox"/> Chest Pain / Angina _____ | <input type="checkbox"/> Allergies / Hay fever _____ | <input type="checkbox"/> Anemia _____ |
| <input type="checkbox"/> Heart Attack _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Stroke / TIAs _____ | <input type="checkbox"/> COPD / Emphysema _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Peripheral Vascular Disease _____ | <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Gout _____ |
| <input type="checkbox"/> Congestive Heart Failure _____ | <input type="checkbox"/> Sexually Transmitted Disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Birth Defect of the Heart _____ | <input type="checkbox"/> Scarlet Fever _____ | <input type="checkbox"/> Thyroid / Endocrine Disease _____ |
| <input type="checkbox"/> Headaches _____ | <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Sleeping Problem / Insomnia _____ | <input type="checkbox"/> Transfusion _____ |

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 ____