HEALTH QUESTIONNAIRE

Name: _____Today's Date:_____

Date of Birth:_____Age:_____

This will be extremely helpful to the doctor. Please complete and return at the time of your appointment. All information is confidential.
Who is your family doctor?:_____Dentist:_____

Chief Complaint: What is your CURRENT most important medical problem, and if know, what is your diagnosis?

_____

_____

_____

Who referred you to our practice?_____

Medications: Please list all current medications, vitamins, hormones (prescription and non-prescription).

Medication Name	Dosage (mg., mEq)	How often taken?	How long have you been taking this medication?

Which pharmacy do you use?_____
Location of pharmacy_____

Are you allergic to any medications? (If you don't know the exact name, tell why the medication might be used.)	Names of Medicine:	Your Allergic Reaction:

PAST OPERATIONS:
Please check (X) any operation you have had. If you can remember, list the year when you had the surgery done.

( )	YEAR	SURGERY:
( )		Heart Bypass (coronary artery bypass)
( )		Other Heart Surgery; Type:
( )		Hysterectomy ( )Both Ovaries removed ( )one or both left in
( )		Appendix
( )		Gallbladder Surgery
( )		Stomach Surgery
( )		Prostate Surgery
( )		Breast Surgery
( )		Joint Replacement Surgery Which joint?
( )		Groin hernia Surgery
( )		Cancer Surgery; Type:
( )		Pace maker/defibrillator device If yes ID#_____
( )		Other; Type?

SERIOUS ILLNESSES:
Do you currently have any of the following problems? Please circle.

a. diabetes
b. stroke
c. tuberculosis
d: high blood pressure
e. heart disease: heart attack/failure
f. kidney Disease
g. liver Disease
h. serious Infections
i. asthma
j. stomach, esophageal or bowel disease
k. thyroid disease
l. other serious illness_____
m. significant infections or transfusions
n. collagen disease - Lupus____

INJURIES: (fractures, head injury, burns, etc)_____

_____

PREVIOUS RADIATION THERAPY? Yes _____ No _____

WHERE	WHEN	WHY	DOCTOR

PREVIOUS CHEMOTHERAPY? Yes_____No_____

Date of your last course:_____

SOCIAL HISTORY:

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Number of children and ages: How far do they live from you?

_____
_____
_____
_____
_____

Number of people in household:_____

Education (Please circle the highest level attended)

1 2 3 4 5 6 7 8	9 10 11 12	13 14 15 16	17+	
Grade School	High School	College	Graduate School	Other

Retired: ( ) YES ( ) NO
Occupation (Previous if retired)_____

Typically we do not match genders when providing care. However, if you have special considerations, please let your physician or nursing staff know. We will do our best to meet your needs.

HABITS-LIFESTYLE:

Do You Smoke?

Now? ( )YES ( ) NO How many years?_____
Past? ( )YES ( ) NO How many years?_____
How many packs per day?_____

If you had a smoking habit but quit, give approximate dates when started and stopped:

_____

How much of the following BEVERAGES do you usually drink?

Cups of coffee/tea _____ per ( )Day ( )Week
Glasses/Bottles of wine/beer _____ per ( )Day ( )Week
Ounces of "hard" liquor _____per ( )Day ( )Week

If you no longer drink any alcoholic beverages, but formerly did, give an approximate date you discontinued:_____

List any regular physical EXERCISE activities you do and describe how often you do them:

Type of Exercise	Times per week

Do you know of any exposure to any dangerous substances or infectious diseases in your occupation(s) or hobby(ies): ( )YES ( ) NO If yes, what types:_____
_____

PLEASE NOTIFY YOUR DOCTOR IN CONFIDENCE IF YOUR PAST OR PRESENT LFESTYLE HAS PLACED YOU IN A SPECIAL HEALTH RISK.

PAST/PRESENT MEDICAL PROBLEMS
Please indicate symptoms or problems you are having now (within the last month),or in the past.

Past	Present		Past	Present	
General			**Head, Eyes,**		**Ears, Nose, Throat**
( )	( )	Anxiety/Nervousness	( )	( )	Double Vision
( )	( )	Depression/manic	( )	( )	Blindness
( )	( )	Recent weight gain	( )	( )	Dryness (mouth or eyes)
( )	( )	Recent weight loss	( )	( )	"Something in eye"
( )	( )	Fever	( )	( )	Mouth sores
( )	( )	Chills	( )	( )	Trouble tasting
( )	( )	Fatigue	( )	( )	Sinus trouble
( )	( )	Alcoholism	( )	( )	Hoarseness
( )	( )	Cancer	( )	( )	Glaucoma
Nervous System			**Bladder,**		**Kidney, Uterus, Prostate**
( )	( )	Dizziness	( )	( )	Blood in urine
( )	( )	Falls causing injury	( )	( )	Burning on urination
( )	( )	Seizures/Convulsions	( )	( )	Bladder infection
( )	( )	Loss of consciousness	( )	( )	Kidney infection
( )	( )	Memory loss	( )	( )	Frequent nighttime urination
( )	( )	Prolonged numbness/tingling	( )	( )	Slow or weak stream
( )	( )	Carpal tunnel Syndrome	( )	( )	Vaginal infection
( )	( )	Headaches or Migraines	( )	( )	Kidney stones
( )	( )	Epilepsy	( )	( )	Menstrual abnormalities
( )	( )	Stroke	( )	( )	Post-menopausal (no longer having periods)

Heart &	**Circulation**	**Muscles,**	**Joints, Bones**
( ) ( )	Shortness of breath lying	( ) ( )	Degenerative arthritis
( ) ( )	Pain in chest	( ) ( )	Gout
( ) ( )	Pain in leg muscles	( ) ( )	Rheumatoid Arthritis
( ) ( )	Prolonged irr heart beat	( ) ( )	Other arthritis
( ) ( )	Swollen legs, ankles or feet	( ) ( )	Back Pain
( ) ( )	Angina (chest pain w activity)	( ) ( )	Joint Pain
( ) ( )	Abnormal heart valve	( ) ( )	Joint swelling
( ) ( )	Blood clot in the leg(Phlebitis)	( ) ( )	Muscle pain/weakness
( ) ( )	Heart failure	( ) ( )	Neck Pain
( ) ( )	Heart attacks(myocardial infarction)	( ) ( )	**STOMACH / INTESTINES**
( ) ( )	High blood pressure	( ) ( )	Abdominal pain
( ) ( )	High cholesterol	( ) ( )	Heartburn
LUNGS	Shortness of breath after:	( ) ( )	Nausea / Vomiting
( ) ( )	-walking 1-2 blocks	( ) ( )	Vomiting blood
( ) ( )	-after one flight of stairs	( ) ( )	Trouble swallowing
( ) ( )	Cough	( ) ( )	Diarrhea
( ) ( )	Asthma (wheezing)	( ) ( )	Constipation
( ) ( )	Pain on taking deep breath	( ) ( )	Black tarry stools
( ) ( )	Coughing up blood	( ) ( )	Loss of appetite
( ) ( )	Blood clot in lung (pulmonary embolus)	( ) ( )	Ulcer
( ) ( )	Chronic lung disease	( ) ( )	Inflam bowel disease (colitis)
( ) ( )	Emphysema, bronchitis	( ) ( )	Irritable bowel syndrome
( ) ( )	Hay fever	( ) ( )	Diverticulitis
( ) ( )	Tuberculosis	( ) ( )	Gallbladder attack
SKIN		( ) ( )	Hiatal hernia
( ) ( )	Rash	( ) ( )	Gallstones
( ) ( )	Welts	( ) ( )	Hepatitis
( ) ( )	Itching	( ) ( )	Inflamed pancreas (Pancreatitis)
( ) ( )	Rash over nose and cheeks	**GLANDS**	
( ) ( )	Patchy or total hair loss	( ) ( )	Diabetes
( ) ( )	Psoriasis	( ) ( )	Underactive thyroid
( ) ( )	Hands turn blue, white or red in cold	( ) ( )	Overactive thyroid
( ) ( )	Tight skin	**BLOOD**	
( ) ( )	Finger ulcer	( ) ( )	Bleeding tendency
( ) ( )	Changing mole	( ) ( )	Anemia
( ) ( )	Sick when in sun		

WOMEN ONLY	GYNECOLOGIC	WOMEN ONLY	GYNECOLOGIC
Last menstrual period		Type of birth control	
Last pap smear		( ) ( )	Irreg/freq periods
( ) ( )	Menopausal symptoms	( ) ( )	Exc flow or spotting between periods
( ) ( )	Hormone Use	( ) ( )	Excessive pain / periods
( ) ( )	Abdnormal pap smear	( ) ( )	Mother took DES hormone during pregnancy
( ) ( )	Family Hx of breast cancer	( ) ( )	
( ) ( )	Vaginal discharge/itching	( ) ( )	**Is there ANY possibility that you are pregnant?**
( ) ( )	Number of pregnancies	( ) ( )	**Do you plan on becoming pregnant?**
	Number of miscarriages/abortions		

BREAST HEALTH HISTORY:

Date of your last mammogram? _____Where?_____
Do you perform Breast Self Examination? YES_____NO_____
At what age was your first menstrual period?_____
At what age was your first live child birth?_____
Do you have a first degree relative with breast cancer (mother and/or sisters, daughters)?

Have you had a previous breast biopsy? YES_____NO_____
Have you ever taken estrogen replacement hormones? YES____NO____
If yes, when?_____

GENERAL:
Any additional information you feel the doctor should know:

(For Physician's Use Only)
KARNOFSKY PERFORMANCE SCORE: _____

Physician Signature: Date: