HEALTH QUESTIONNAIRE

Name:_____Today's date:_____

Date of Birth:_____Age:_____

Please complete and return at the time of your appointment. This will be extremely helpful to the doctor. All information is confidential.

CHIEF COMPLAINT: What is your CURRENT most important medical problem?

What brings you to the doctor today?

Who referred you to this doctor?_____

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 to you use?_____
Location of pharmacy_____

PLEASE LIST ALLERGIES: (Food, medications, etc.)

Flu Shot: Yes/ No Approximate date _____
Pneumonia Shot: Yes/ No Approximate date _____

OPERATIONS:

Operations	Date	Hospital	Surgeon

SERIOUS ILLNESSES: _____

_____

_____

INJURIES: (Fractures, head injury, burns, etc.)

_____

_____

PREVIOUS RADIATION THERAPY? YES_____NO_____

WHERE	WHEN	WHY	DOCTOR

PREVIOUS CHEMOTHERAPY? YES_____NO_____
DATE OF YOUR LAST COURSE OF CHEMOTHERAPY?_____

PERSONAL HISTORY:

Occupation:_____

Retired? YES_____ NO_____

Are you: Single _____Married _____Divorced _____Widowed_____

Living with Spouse? YES_____ NO_____

Do you live with anyone else besides your spouse: (children, parents, significant other)

Names and relationship:_____

Education:_____

Have you completed a Living Will or advance directive? YES_____NO_____

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.

FAMILY HISTORY:

Has anyone in your family been diagnosed with cancer? YES_____NO____

If yes, describe how the person is related to you, and what type of cancer, ie, breast, lung, brain, etc._____

DAILY HABITS:

1: Are you on any special diet? YES_____NO_____If so, what kind of diet?_____
2: Do you use alcohol: YES_____NO____How much?_____
3: Past heavy alcohol use? YES_____NO____
4: Have you used recreational or illegal drugs? YES_____NO_____
5: Are you at increased risk of HIV or AIDS? YES_____NO_____
6: Asbestos exposure? YES_____ NO_____ WHERE_____
7: Chemical exposure? YES_____NO_____WHAT KIND?_____

CARDIAC RISK FACTORS:

1: Have you ever smoked? YES ____NO ____How much?_____
For how many years? _____When did you quit?_____
2: High blood pressure? YES ____NO _____For how long?_____
3: Diabetes: YES ____NO ____For how long?_____
4: High cholesterol? YES_____NO_____
5: Any family history of sudden death, heart attack, high blood pressure, or heart surgery? YES _____NO _____If yes, who and at what age?_____
Do you have a cardiac pacemaker or defibrillator device? YES_____ NO_____
If yes, what is the manufacturer ID number? _____

SYMPTOM REVIEW:
Do you currently have any of the following problems? Please circle:

General:
Recent symptoms of:
a. chills
b. fever
c. sweats
d. changes in weight
e. fatigue
f. nervousness
g. insomnia, difficulty sleeping
h. sadness, crying or depression

Comments:_____

Cardiovascular:
a. chest pain
b. palpitations
c. murmur
d. cramping in legs when you walk
e. swelling
f. abnormal EKG

Comments:

Respiratory:
a. cough
b. blood tinges phlegm
c. wheezing
d. short of breath with exertion
e. abnormal chest x-ray

Comments:

Gastrointestinal:
a. vomiting of blood
b. bloody stools, black stools
c. difficulty swallowing
d. jaundice
e. gallbladder trouble
f. diverticulitis
g. colitis
h. diarrhea
i. constipation
j. hemorrhoids
k. nausea
l. heartburn
m. abdominal pain

Comments:

Genitourinary:

a. urinary frequency during the day
b. urination at night ___times
c. trouble starting urination
d. painful urination
e. urgency
f. decreased stream
g. blood in urine
h. urinary infections
i. urinary stones
j. prostate disease
k. testicle lumps

Comments:
_____

Metabolic:

a. heat or cold intolerance
b. goiter
c. excessive thirst
d. history of diabetes

Comments:_____
_____

Hematologic:

a. anemia
b. blood transfusions
c. bleeding tendency
d. easy bruising
e. blood clotting trouble

Comments: _____

Skin:

a. rash
b. changing moles
c. skin trouble/eczema

Comments:_____
_____

Neurologic:

a. headache
b. stroke
c. seizures
d. passing out
e. localized weakness or loss of muscle function
f. localized numbness or loss of muscle sensation

Comments:_____

Musculoskeletal:

a. bone pain
b. arthritis
c. broken bones
d. muscle ache
e. back pain

Comments:_____

Women only: (Men, please skip down to the end of the page to **"General")**

GYNECOLOGIC:

Is there any possibility you are pregnant or do you plan on becoming pregnant?
YES_____NO____

a. last menstrual period_____
b. last pap smear_____
c. hysterectomy
d. menopausal symptoms
e. hormones
f. abnormal pap smears
g. family history of breast cancer
h. vaginal discharge or itching
i. number of pregnancies_____
j. number of miscarriages/abortions___
k. type of birth control_____
l. irregular/frequent menstrual periods__
m: excessive flow or spotting between periods
n. excessive painful periods
o. mother took DES hormone during pregnancy

Comments:_____

BREAST HEALTH HISTORY:

Date of your last mammogram? _____Where?_____
Do you perform Breast Self Examination? YES_____NO_____
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____
Do you have a history of in situ breast cancer? 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: