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Health Questionnaire

Name: ____ Today's date: ________________

FAMILY HISTORY:

Medical problems in your blood relatives: Please mark the appropriate space with **M** or **F** if that condition affected your mother or father, **B** or **S** if it affected your brother or a sister, **C** for child and **GP** for a grandparent:

___Gallstones ___ Ulcers ___ Diabetes ___Arthritis ___Celiac disease (Gluten allergy)
___Colon polyps ___Colon cancer ___Colitis/ Crohn's disease ___ Irritable Bowel Syndrome
___ Hemochromatosis (iron storage disease) ___Hepatitis ___ Other liver diseases: What type: ____________________
___Heart disease ___High blood pressure ___Cancer: What type ________________________
___Depression ___Genetic diseases: What type ____

YOUR HEALTH HISTORY: Have you ever had any of these medical problems:

☐ Colon polyps ☐ Colon Cancer ☐ Ulcerative colitis ☐ Crohn's ☐ Gallstones ☐ Diverticulitis
☐ Celiac disease (Gluten allergy) ☐ Ulcers ☐ Problems with excessive bleeding
☐ Hepatitis ☐ Jaundice ☐ Other liver Problems:____
☐Pancreatitis ☐ Diabetes ☐ High blood pressure ☐ Heart attacks ☐ Rheumatic fever
☐ Breathing difficulty ☐ Tuberculosis ☐ Sleep apnea ☐ Depression ☐ Arthritis
☐ Cancer: What type: _________________ ☐ Kidney stones ☐ Thyroid problems ☐ Stroke
☐ Infections: What type: ________________ ☐ Are you on Aspirin or other blood thinners? Which one:__________________

HAVE YOU HAD ANY SURGERIES:

Date What was done
_______ ____
_______ ____
_______ ____
_______ ____
_______ ____

HAVE YOU BEEN IMMUNIZED AGAINST ANY OF THE FOLLOWING:

☐ Hepatitis A ☐ Hepatitis B ☐ Tetanus ☐ Mumps ☐ Flu shot

MEDICATIONS YOU ARE TAKING: (Include vitamins, herbs and other over-the-counter products):

Name of medication	Strength	How often taken	Reason taken

MEDICATIONS YOU ARE ALLERGIC TO: ☐ I am not aware of any drug allergies.

Name of medication	When did the reaction occur?	What was the reaction?

PHARMACY INFORMATION:

NAME OF THE PHARMACY YOU USE REGULARLY:_________________________ **CITY:** ______________________

ADDRESS OR NEAREST CROSS STREET:_____________________________________ **PHONE:**____________________

HAVE YOU HAVE HAD ANY OF THE FOLLOWING TESTS:

	When	Results
☐ **Ultrasound**	_______________	____
☐ **CAT scan of the abdomen**	_______________	____
☐ **Colonoscopy**	_______________	____
☐ **Endoscopy of the stomach (EGD)**	_______________	____

SOCIAL HISTORY:

Place of Birth (include country if you were not born in the US):____

Current Occupation: __________________________________ **Have you been exposed to hazardous material?** ____ **No** ___ **Yes :**_________________________

Were you a smoker ever? ____**No** ____**Yes: Age began** ____**. Age quit** ____**. Number of packs per day** ____**. Are you currently smoking:**____**No** ____**Yes**

Do you drink alcohol? ____**No** ____**Yes: What kind?** ____________________________________ **How often?** ____________________

Do you drink ____**sodas or** ____ **coffee? Daily?** _____ **If not daily then how often?** ___________________ **How many per day?** __________________

Do you exercise: ____**No** ____**Yes: How often:**___________ **What type of exercise:**____

REVIEW OF SYSTEMS: (Check where applicable for recent occurrence)

Head and Neck:
- ☐ Frequent headaches
- ☐ Neck pain
- ☐ Neck lumps

Eyes :
- ☐ Change in vision
- ☐ Double vision
- ☐ Eye pain or redness
- ☐ See fixed spots

Ears:
- ☐ Hearing difficulty
- ☐ Ringing ears
- ☐ Earache
- ☐ Discharge from ears

Mouth:
- ☐ Pain on chewing
- ☐ Bleeding gums
- ☐ Sore gums or mouth

Nose and throat:
- ☐ Frequent nosebleeds
- ☐ Change in voice
- ☐ Nasal congestion

Respiratory:
- ☐ Wheezing
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Recent colds

Cardiovascular:
- ☐ High blood pressure
- ☐ Irregular heartbeats
- ☐ Heart attacks
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Leg swelling

Digestive System:
- ☐ Problem swallowing
- ☐ Heartburn
- ☐ Belching
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Bloating
- ☐ Black stools
- ☐ Blood in the stools.
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diverticulosis
- ☐ Hemorrhoids
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Blood transfusion
- ☐ Use of street drugs
- ☐ Contact with hepatitis
- ☐ Jaundice

Extremities:
- ☐ Swelling or redness of the joints
- ☐ Rash over the legs
- ☐ Leg cramps

Urinary:
- ☐ Frequent urination at night
- ☐ Burning on urination
- ☐ Urgency to urinate
- ☐ Blood in the urine
- ☐ Difficulty starting urine stream

Male Reproductive System:
- ☐ Thin urine stream
- ☐ Lumps or pain in the testicle
- ☐ Prostate problems

Female Reproductive System:

Last menstrual period: _____________

Last GYN exam: __________________

- ☐ Are you currently pregnant
- ☐ Do you have irregular periods
- ☐ Heavy menstrual flow
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Breast lumps

Skin:
- ☐ Easy bruising
- ☐ Change in color
- ☐ Itching or burning

Neurological:
- ☐ History of seizures
- ☐ Easy fainting
- ☐ Tremors
- ☐ Numbness in extremities
- ☐ Weakness in extremities
- ☐ Backache

Mood:
- ☐ Difficulty relaxing
- ☐ Feel excessively stressed
- ☐ Suicidal ideas
- ☐ Desire psychiatric help

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Signature