HEALTH QUESTIONNAIRE

NAME	AGE	HEIGHT	DATE
ADDRESS		WEIGHT	PHONE

HISTORY OF PAST ILLNESS: Childhood	Yes	No		Yes	No
Have you had?			***Have you had?***		
Measles			Rheumatic fever or heart disease		
Mumps			Tuberculosis		
Chicken Pox			Venereal Disease		
Diabetes			Congenital Abnormalities		
Strokes			Other Serious Diseases:		
Cancer					

HISTORY OF PAST ILLNESS: Adult	Yes	No
Have you had any serious illnesses?		
Have you ever been hospitalized or been under medical care for very long?		
If Yes, for what reason?		

HISTORY OF PAST ILLNESS: Operations	Yes	No
Have you had any surgery?		
If Yes, Please List:		

HISTORY OF PAST ILLNESS: Injuries	Yes	No
Have you had any broken bones?		
Have you had any head concussions or injuries?		
Have you ever been knocked unconscious?		

FAMILY HISTORY						Yes	No
If Living:	**Age**	**Health**	**If Deceased:**	**Age (at death) & Cause**	***Has any blood relatives ever had:***		
Father					Cancer		
Mother					Tuberculosis		
Brother/Sister					Diabetes		
					Heart Trouble		
					High blood pressure		
Husband/Wife					Sroke		
Son/Daughter					Convulsions		
					Suicide		
					Insanity		
					Bleeding tendency		
					Gout or other arthritis		

SOCIAL HISTORY

Circle One:

Alcoholic Beverages: Never Rarely Moderately Daily Ever?

Tobacco: Cigarettes _____ packs a day Don t smoke Ever smoked?

Are you exposed to fumes, dusts, or solvents?

SYSTEMIC REVIEW:	Yes	No		Yes	No
Do you have any of the following:			**Head-Eyes-Ears-Nose-Throat (cont d):**		
General:			Headaches		
Recent weight change?			Glaucoma		
Have you been in good general health most of your life?			Itching eyes or nose		
Skin:			Sneezing or runny nose		
Skin Disease			Nosebleeds		
Jaundice			Chronic sinus trouble		
Hives, eczema or rash			Ear disease		
Frequent infection or boils			Impaired hearing		
Abnormal pigmentation			Dizziness or short term episodes of unconsciousness		
Head-Eyes-Ears-Nose-Throat:			**Neck:**		
Eye disease or injury?			Stiffness		
Do you wear glasses?			Thyroid trouble		
Double vision			Enlarged glands		

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SYSTEMIC REVIEW (cont'd)	Yes	No
Respiratory:		
URI (cold) now		
Spitting up blood		
Chronic or frequent cough		
Asthma or Wheezing		
Difficulty breathing		
Any trouble with lungs		
Pleurisy or Pneumonia		
Cardiovascular:		
Chest pain or angina pectoris		
Shortness of breath with walking or lying down		
Difficulty walking two blocks		
Heart trouble or heart attacks		
High blood pressure		
Swelling of hands, feet,or ankles		
Awakening in the night smothering		
Heart murmur		
Gastrointestinal:		
Peptic ulcer (stomach or duodenal)		
Vomiting blood or food		
Gallbladder disease		
Liver trouble		
Hepatitis		
Painful bowel movement		
Bleeding with bowel movements		
Black stools		
Hemorrhoids or piles		
Recent change in bowel habits		
Frequent diarrhea		
Heartburn or indigestion		
Cramping or pain in the abdomen		
Does food stick in your throat		
Genitourinary:		
Loss of urine		
Frequent urination		
Night time urinating		
Burning or painful urination		
Blood in urine		
Kidney trouble		
Kidney stones		
Bright s Disease		

SYSTEMIC REVIEW (cont'd)	Yes	No
Gynecological:		
Age periods started:		
How long do periods last? days		
Number of pregnancies		
Number of miscarriages		
Date of last cancer smear and results		
Frequency of periods, every days.		
Any pain with your periods		
Number of children Ages		
Date of first day of last period		
Musculo-skeletal:		
Varicose veins		
weakness of muscles or joints		
Any difficulty walking		
Any pain in calves or buttocks on walking		
relieved by rest?		
Neuro-Psychiatric:		
Have you ever had psychiatric care?		
Have you been advised to see a psychiatrist?		
Do you ever have, or have had, fainting spells?		
Convulsions		
Paralysis		
Hematologic:		
Are you slow to heal after cuts?		
Blood disease		
Anemia		
Phlebitis		
Have you had difficulty with bleeding excessively		
after tooth extraction or surgery?		
Have you had abnormal bruising bleeding?		
Allergic:		
Any allergies, including medication		
Endocrine:		
Thyroid disease		
Hormone therapy		
Any change in hat or glove size		
Any change in hair growth		
Have you become colder than before or		
skin become dryer?		

ALLERGIES AND SENSITIVITIES

1. Is there a history of skin reactions or other adverse reaction or sickness following injection or oral administration of:

	Yes	No
Penicillin or other antibiotics		
Morphine, Codeine, Demerol, or other narcotics		
Novocain or other anesthetics		
Aspirin, empirin or other pain remedies		
Sulfa drugs		
Tetanus antitoxin or other serums		
Adhesive tape		
Iodine or merthiolate		
Any other drug or medication		
Any foods, such as egg, milk, or chocolate		

List other known allergies.

Have you ever received treatment for:	Yes	No
Asthma		
Rheumatism		
Rheumatic Fever		

2. Drugs Recently Taken: Withing the past 6 months	Yes	No
Cortisone		
ACTH		
Anticoagulants		
Tranquilizers		

	Yes	No
Hypertensive (high blood pressure medicines)		
Aspirin		

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Physician _____ Date _____ Signature of patient _____