Health Questionaire

Name: Date of Birth: Date:

Occupation: Revised 2/3/2015

Past Medical and Family History

	Self	Family (Specific Family Member)		Self	Family (Specific Family Member)
Recent Weight Loss			Kidney/bladder problems		
Migraine Headaches			Neurological problems		
Epilepsy/Convulsions			Arthritis		
Eye disease			Osteoporosis		
Hearing disorder			Cancer-Type(cancer type/family member)		
Recurrent nose bleeds					
Recurrent sinus/throat infections			Bleeding disorder		
Angina - Chest pain			Blood transfusion(s)		
Heart Attack			Anemia		
High Blood Pressure			Diabetes		
Stroke			Thyroid disorder		
High Cholesterol			Alcohol/Drug abuse		
Heart valve disorder			Mental illness		
Lung disease			Depression/Anxiety		
Stomach Ulcer			Psoriasis/Eczema		
Bowel Problems			Hair Loss		
Liver disease/Hepatitis			Accident-Major		

Hospitalizations/Surgeries

Year	Illness/Operation	Year	Illness/Operation

List All Current Medications You Take		
Medication	Dose	Frequency

Do you Now OR Have you Ever Consumed

Cigarettes Y N Daily Amt_____# Yrs_____

Alcohol Y N Drinks/WK_____

Caffeine Y N Cups/Day_____

Drugs Y N Type_____

The Last time (Year) you had;

Flu Vaccine (type?)_____TB test_____

Pneumonia 23 vaccine_____Prevnar 13 vaccine_____

T.B. Test_____ Hepatitis B vaccine_____,_____,_____

Td (tetanus) shot_____Tdap_____

Stool blood test_____ PSA_____

Cholesterol Test_____ Colonoscopy_____

Dental Exam_____ Eye exam_____

Breast Exam _____

_____ Pap _____ Normal _____ ABN

_____ Bone Density _____ Normal _____ ABN

_____ Mammogram _____ Normal _____ ABN

Drug Allergies	
Drug	**Reaction**

For Women Only

Date of Last Cycle:

Birth Control ◯Y ◯N

Type:_____

How Many:

Pregnancies_____

Births_____

Abortions_____

Miscarriages_____

Is your Child around Secondhand Smoke?

Y◯ N◯