Health Questionnaire

Name_____ **Age**_____ **Date**_____ **Ht**____ **Wt**_____ **BP**_____ **HR**____

Reason for Visit:_____

Past Medical History/ Type of Medical Problems:_____

Past Surgeries/ Last colonoscopy and results_____

Last pap smear (month/year) and results:_____ Hysterectomy No Yes

Last mammogram (month/year) and results: _____

Lat Tetanus Vaccine_____ **Last Pneumonia Vaccine**_____ **Last Flu Vaccine**_____

Family History: Any family members have any of the following

Cancers	No	Yes	Who	Type of Cancer_____
Strokes	No	Yes	Who	_____
Heart trouble	No	Yes	Who	_____
High blood pressure	No	Yes	Who	_____
Diabetes	No	Yes	Who	_____
Mental Illness	No	Yes	Who	_____

Social History

Any Drug Use	No	Yes	Type_____
Any Alcohol Use	No	Yes	How often_____
Single Married Separated Divorced		Widowed	
Children	No	Yes	How many_____
Employed	No	Yes	Type of work_____
Smoking	No	Yes	Frequency_____

Allergies to medications_____ **Medications** Please list on back side of paper

Review of System

General			Genitourinary		
Fever	No	Yes	Loss of urine	No	Yes
Chills	No	Yes	Frequent urination	No	Yes
Unexpected weight loss	No	Yes	Burning/pain in urination	No	Yes
			Blood in urine	No	Yes
Head/Neck/Eyes/Ear Nose/Mouth/Throat					
Loss of Consciousness	No	Yes	Musculoskeletal/Skin/Breast		
Dizziness	No	Yes	Weakness of muscle/joints	No	Yes
Sudden vision change	No	Yes	Difficulty walking	No	Yes
Neck stiffness	No	Yes	Rash	No	Yes
Enlarged glands	No	Yes	Skin disease	No	Yes
Itchy Eyes	No	Yes	Abnormal skin pigmentation	No	Yes
Recent Eye Injury	No	Yes	New breast lumps	No	Yes
Ear Pain	No	Yes	Breast pain	No	Yes
Ear Drainage	No	Yes	Nipple Drainage	No	Yes
Hearing Loss	No	Yes			
Nose bleeds	No	Yes	Neurological/Psychological		
Runny nose	No	Yes	Seizures	No	Yes
Mouth lesions	No	Yes	Paralysis	No	Yes
Mouth Pain	No	Yes	Suicidal thoughts	No	Yes
Throat pain	No	Yes	Thoughts of hurting others	No	Yes
Heart/Lung			Endocrine/ Hematologic/Lymphatic		
Chest Pain	No	Yes	Change in hair growth	No	Yes
Shortness of breath	No	Yes	Feeling more hot/cold	No	Yes
Hand/feet/ankle swelling	No	Yes	Skin becoming more dry	No	Yes
Coughing	No	Yes	Blood disease	No	Yes
Wheezing	No	Yes	Abnormal bleeding	No	Yes
Difficulty breathing	No	Yes			
Gastrointestinal					
Vomiting	No	Yes	Blood in stool	No	Yes
Change in bowel habits	No	Yes	Abdomen pain	No	Yes
Diarrhea	No	Yes			

How did you hear about the clinic? Family/Friend Insurance Website Insurance Agent Insurance Co Auto-Assign Internet Postcard