Health Questionnaire

Name ______________________ Date of birth ____/____/____ Today's Date ______________

Occupation ______________________ SS# ________-____-________ Age __________

Married ____ Single ____ Divorced ____ Widowed ____ Male ____ Female ____ Date of birth ______________

Date of last exam ____________ Last tetanus shot? ________ Who were you referred by? ______________

Chief Complaint ____

*Do you have an Advanced Directive? Yes _____ No _____ [for office use only: Offered _____ DNR _____ CPR _____]

Drug Allergies

____
____
____

Current Meds (Include OTC & Vitamins)

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____
____

Continue on back if necessary

Family History (please check ALL that apply)

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Drug Addiction	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐

Hospitalization or Surgery

Reason	Date	Reason	Date

Medical History (please check ALL that apply & give date of onset or procedure)

- ☐ Hypertension ______
- ☐ High Cholesterol ______
- ☐ Heart Palpitations ______
- ☐ Heart Murmur ______
- ☐ Irregular Heart Rate ______
- ☐ Chest Pain / Angina ______
- ☐ Heart Attack ______
- ☐ Stroke / TIAs ______
- ☐ Peripheral Vascular Disease ______
- ☐ Congestive Heart Failure ______
- ☐ Birth Defect of the Heart ______
- ☐ Headaches ______
- ☐ Alcoholism ______
- ☐ Dizziness / Fainting ______
- ☐ Anxiety / Depression ______
- ☐ Fatigue ______
- ☐ Shortness of Breath ______
- ☐ Foot Problem ______
- ☐ Allergies / Hay fever ______
- ☐ Asthma ______
- ☐ COPD / Emphysema ______
- ☐ Pneumonia ______
- ☐ Sexually Transmitted Disease ______
- ☐ Scarlet Fever ______
- ☐ Rheumatic Fever ______
- ☐ Sleeping Problem / Insomnia ______
- ☐ Ulcer ______
- ☐ Heartburn / GI Disorder ______
- ☐ Sexual Problem ______
- ☐ Menstrual Problem ______
- ☐ Bladder Problem ______
- ☐ Anemia ______
- ☐ Arthritis ______
- ☐ Osteoporosis ______
- ☐ Gout ______
- ☐ Diabetes ______
- ☐ Thyroid / Endocrine Disease ______
- ☐ Cancer ______
- ☐ Transfusion ______

Tobacco products: Type & Amount daily ______________________ Interested in quitting? Yes ____ No ____

Have you ever used "recreational drugs"? Yes ____ No ____ if yes, what type: ______________________

Alcohol: Type & Amount daily ______________________ Coffee/Caffeine: Amount daily ____________

Do you like your work? Yes ____ No ____ Hobbies/Sports: ______________________

Exercise routine: ____

Women only:

Date of last period __________ Pregnancies/Live births: ____/____ Birth control method: ________

Planning pregnancy? Yes ____ No ____

Men only: Do you occasionally experience erection difficulties? Yes ____ No ____