

HEALTH QUESTIONNAIRE

(The purpose of this questionnaire is to assist the doctor with your care)

Name _____ Age _____ Birth Date _____ Occupation _____

Education _____ Religion _____

Circle: Single, Married (_____ years), Widow, Divorced, Separated, Remarried

Date of Physical examination _____

Circle the **Main** reason you came to see the doctor.

Pain Menstrual Problem Discharge Possible Pregnancy Urinary Problems Birth Control Routine Check Pap Infertility

Other _____

Note: This is part of your medical record and is kept confidential. It will not be released to any person without your written consent.

Please circle YES or NO answers

FAMILY HISTORY	Living		Deceased	Disease in blood relatives		who
	age	health	cause	(circle yes or no)		
Father				Breast Cancer	Yes No	_____
Mother				Ovarian Cancer	Yes No	_____
Brothers & sisters	1			Cancer, other	Yes No	_____
	2			Colon Cancer	Yes No	_____
	3			Tuberculosis	Yes No	_____
	4			Diabetes	Yes No	_____
	5			Heart trouble	Yes No	_____
Husband				High Blood Pressure	Yes No	_____
Children	1			Asthma	Yes No	_____
	2			Arthritis	Yes No	_____
	3			Epilepsy	Yes No	_____
	4			Birth Defects	Yes No	_____
	5			Genetic disorders (type)	Yes No	_____
				Other	Yes No	_____

PERSONAL HISTORY

HEIGHT _____
 WEIGHT _____ one year ago _____
 Maximum _____ when _____
 Have you been hospitalized for any illness?
 Yes No
 Give details _____

PREVIOUS SURGERY **Year**

Yes No Tonsils
 Yes No Appendix
 Yes No Gallbladder
 Yes No Breast
 Yes No Varicose veins
 Yes No Hemia
 Yes No Laparoscopy
 Yes No Dilation & Curettage (D&C)
 Yes No Hysterectomy
 Yes No Ovaries
 Yes No Tubes
 Yes No Others: list _____

Have you ever been advised to have any surgical operation which has not been done?
 Yes No

TRANSFUSIONS

Yes No Blood
 Yes No Plasma
 Yes No Other

ALLERGIES

Yes No Penicillin
 Yes No Sulfa
 Yes No Tetracycline
 Yes No Other Antibiotics
 Yes No Codeine
 Yes No Novocain/Anesthetics
 Yes No Other drugs
 Yes No Foods
 Yes No Other
DO YOU USE
 Yes No Caffeine
 Yes No Tobacco
 Yes No Alcohol
 Yes No Social/recreational drugs

CURRENT MEDICATIONS

Yes No Laxatives
 Yes No Vitamins
 Yes No Tranquilizers
 Yes No Sleeping pills
 Yes No Thyroid
 Yes No Diet pills
 Yes No Water pills
 Yes No Heart pills
 Yes No Blood pressure pills
 Yes No Hormones
 Yes No Birth Control
 Yes No Aspirin
 Yes No Ibuprofen
 Yes No Others

CHILDHOOD ILLNESS

Yes No Rubella (German Measles)
 Yes No Measles
 Yes No Mumps
 Yes No Chicken Pox
 Yes No Scarlet Fever
 Yes No Rheumatic Fever

ADULT ILLNESS

Yes No Pneumonia
 Yes No Bronchitis
 Yes No Tuberculosis
 Yes No Asthma
 Yes No Cancer
 Yes No Diabetes
 Yes No Arthritis
 Yes No Back Trouble
 Yes No Anemia
 Yes No Jaundice, Hepatitis
 Yes No Ulcer
 Yes No Seizures or convulsions
 Yes No Depression
 Yes No Phlebitis, blood clot
 Yes No Migraine headache
 Yes No Varicose veins
 Yes No Kidney disease
 Yes No Bladder infection
 Yes No Gallbladder infection
 Yes No Mononucleosis
 Yes No Meningitis/Encephalitis
 Yes No Heart murmur/MVP
 Yes No Heart attack/Angina
 Yes No Stroke (CVA)
 Yes No Thyroid disease
 Yes No Hypertension
 Yes No Hemorrhoids
 Yes No Endometriosis
 Yes No Exposed to or tested positive for HIV
 Yes No Did your mother take any medications when she was pregnant with you, esp. DES.
 Yes No Others