REASON FOR VISIT AND HEALTH QUESTIONNAIRE

FAMILY HISTORY

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING.PLEASE CIRCLE THE NUMBER AND INDICATE WHICH RELATIVE

1. EPILEPSY	6. THYROID	11.OSTEOPOROSIS	16. HIGH CHOLESTEROL	
2. MIGRAINE	7. HAYFEVER	12. ARTHRITIS	17. ALCOHOLISM	
3. MENTAL ILL.	8. ASTHMA	13. HEART DISEASE	18. HEPATITIS	
4. GLAUCOMA	9. ANEMIA	14. STROKE	19. CANCER	
5. DIABETES	10. BLEEDS EASILY	15 HYPERTENSION		

HOSPITAL ADMISSIONS (NOT INCLUDING PREGNANCIES)

YEAR	ILLNESSES OR OPERATIONS

LIST ALL MEDICATIONS YOU ARE NOW TAKING (WITH AND WITHOUT PRESCRIPTION		ALLERGIES

MEDICAL HISTORY (CHECK ANY OF THIS DISEASES ANDILNESSES THAT APPLIES TO YOU)

__ Decreased hearing
__ Ringing Ear
__ Ear Infections-frequent
__ Dizzy spells __ Fainting spells
__ Failing Vision __ Eye pain
__ Double or Blurred Vision
__ Nose Bleeds-recurrent
__ Sinus trouble
__ sore throat-frequent
__ Hoarseness-prolonged
__ Hay fever/Allergies
COMPLETE
__ Bronchitis / Chronic Cough
__ Asthma / wheezing
__ Shortness of Breath:
__ on exertion __ lying flat
__ Chest Pain
__ High blood pressure
__ Heart Murmur __ Swollen ankles
__ Irregular Pulse __ Palpitations
__ Leg pain-when walking
__ Varicose veins / Phlebitis
__ Cold numb feet
__ Blood Transfusions

__ Loss of appetite-recent
__ Difficulty of swallowing
__ Heartburn __ Peptic Ulcer
__ Persistent nausea / vomiting
__ Abdominal pain-chronic
__ Gall bladder trouble
__ Jaundice / hepatitis
__ Diarrhea __ Constipation
__ Diverticulosis __ Crohn's / Colitis
__ Bloody or tarry stools
__ Hemorrhoids __ Hernia

__ Urgency to urinate __ with leakage
__ Decrease in force / flow __ painful
__ Stress incontinence-urine-leakage with exercise/movement
__ Blood in urine __ Kidney stones
__ Urine Infections-frequent
__ Sexually Transmitted Disease
__ Weight Loss __ gain-recent
__ Anemia __ bruise easily
__ Cancer __ chronic fatigue

__ Diabetes __ Thyroid disease
__ Seizures __ Stroke
__ Tremor / hands shaking
__ Numbness / tingling sensations
__ Headaches-frequent
__ Arthritis / Rheumatism
__ Back Pain-recurrent
__ Bone fracture / joint injury
__ Osteoporosis
__ Foot pain __ gout
__ Rashes __ Eczema

__ Sleeping or concentration difficulty
__ Depression __Nervousness
__ Agitation __ Memory loss
__ Moodiness __ Suicidal thoughts
__ Phobias __ Mental illness
__ Feeling of worthlessness
__ Rheumatic fever __ Scarlet fever
__ Chicken pox __ Polio __ Mumps
__ Measles __ German measles
__ Tuberculosis
__ Aids / HIV
__ Herpes

__ Alcohol _____ oz. per wk
__ Coffee /Tea ___ cups/day
__ Smoking __ cig/day __#yrs
year quit ___
__ Exercise _____
__ Street drugs
__ Acupunctures / tattoos
Hair loss:
__ progressive __ recent

FEMALES-PLEASE

Menstrual Flow:
__ Reg. __ Irreg. __Cramps
Days of Flow _____
Length of Cycle _____
__ Pain/Bleeding during or after sex
Number of:
Pregnancies ___ Abortions
Miscarriages ___
__ Flushing / Menopause
__ Date of last mammogram

Notes:
