

Please answer these questions concerning your health status. This general information will help your doctor take better care of you. Of course, all information is confidential.

Health History

Name _____ Age _____

What is the main reason for today's visit? _____

Family Doctor's Name, Address and Telephone Number _____

Health Habits

Please answer each question by checking the appropriate box.

Do you...

- Yes No Smoke cigarettes?
_____ packs per day_____
- Yes No Chew tobacco?
How much?_____
- Yes No Drink beer?
_____ bottles per_____
- Yes No Drink wine?
_____ oz. per_____
- Yes No Drink hard liquor?
_____ oz. per_____
- Yes No Use aspirin or Ibuprofen?
How often?_____
- Yes No Drink beverages with caffeine?
_____ cups/day_____
- Yes No On a special diet?
What type?_____
- Yes No Do you exercise LESS than twice a week?

Current Medications and Dose

Drug	Strength	<input type="checkbox"/> NONE How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Operations

What was done?	About when?	<input type="checkbox"/> NONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to Medications

Allergies to Medications	<input type="checkbox"/> NONE
_____	_____
_____	_____
_____	_____

Have you ever had a reaction or sensitivity to latex?

Yes No

Family Health History

Do these problems run in your family?

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Brothers/Sisters	Sons/Daughters	Other
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Study of Systems

Please check the boxes of those conditions which affect you...

General

- Unexpected Weight Loss
- Recent Weight Gain
- Fever or Shaking Chills
- Night Sweats
- Swollen Glands
- Take Coumadin, Blood-thinners

Skin

- Severe Itching
- Persistent Rash
- Changing Moles
- Psoriasis

Head

- Severe Headaches
- Double Vision
- Glaucoma
- Cataracts
- Difficulty Hearing
- Ringing in Ears
- Wear Hearing Aid
- Wear Dentures
- Loose Teeth
- Removable Bridge
- Bleeding Gums
- Severe Nosebleeds
- Frequent Sore Throats
- Persistent Hoarseness

Blood

- Blood Transfusion in Past 6 Months
- Prolonged Bleeding from Surgery
- Anemic in Past
- Ever Treated for Cancer
- Think I'm at High Risk for AIDS

Muscles and Joints

- Muscle Cramps
- Muscle Weakness
- Arthritis or Joint Pain
- Frequent Back Pain

Heart and Lungs

- High Blood Pressure
- High Cholesterol
- Heart Disease
- Heart Attack in Past
- Fainting Spells
- Irregular Heartbeat
- Wear Pacemaker
- Chest Pain
- Shortness of Breath
- Can't Breathe When Flat
- Awaken Short of Breath
- Ankles Swell
- Heart Murmur
- Mitral Valve Prolapse
- Artificial Valve
- Frequent Cough
- Cough up Sputum
- Cough up Blood
- Wheezing or Asthma
- Rheumatic Fever as Child

Digestive Tract

- Poor Appetite
- Nausea
- Vomiting
- Frequent Heartburn
- Heartburn Awakens
- Trouble Swallowing
- Hiatal Hernia in Past
- Rectal Bleeding
- Black Bowel Movements
- Vomited Blood
- Ulcers in Past
- Abdominal Pain
- Diarrhea
- Lost Bowel Control or Soiling
- Constipation
- Bowel Habit Unpredictable
- Milk or Lactose Intolerance
- Colon Polyps in Past
- Colon Cancer in Past
- Liver Disease or Jaundice
- Gallstones

Kidneys

- Kidney Stones
- Kidney Disease
- Frequent Urination
- Up Nights to Urinate
- Blood in Urine
- Painful Urination
- Slow Urination
- Leakage of Urine

Brain

- Epilepsy or Seizures
- Past Strokes

Emotions

- Often Depressed
- Cry Easily
- Overly Anxious
- Can't Handle Stress

Men Only

- Lump in Testicles
- Penis Discharge
- Erection Difficulties

Women Only

- Pregnant Now
- Planning Pregnancy
- Nipple Discharge
- Lump in Breast
- Vaginal Discharge
- Hot Flashes
- Non-period Bleeding
- Past Menopause
- Painful Intercourse
- Change in Periods
- Past Endometriosis

Thank you for completing this questionnaire.