HEALTH QUESTIONNAIRE

PAST MEDICAL AND SURGICAL HISTORY:

Do you have any medical conditions or illnesses? Please list:

____

____

____

____

Have you had any operations? Please list:

____

____

Females: What age did you start menstrual cycles? ____ Do you or (if postmenopausal) did you have irregular cycles? _____

Did you have diabetes during pregnancy or any children born heavier than 10 lbs? _____________

How many pregnancies? _____ How many children? _____ Date of last menstrual cycle: ___________

Males: How many children have you fathered? ________

CURRENT MEDICATIONS: Please list name and dosage: ______________________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

ALLERGIES: Are you allergic to any medications? Please list the **medication name** and the **reaction it caused**:

____

FAMILY HISTORY: Please list **age** and **health issues**, if any. If deceased, please state **age at death** and **cause**.

Father ______________________ **Siblings:** ______________________

Mother ______________________ ______________________

Has any blood relative ever had: Diabetes _________ Thyroid condition __________ Any cancer _________

Heart trouble _________ High cholesterol __________ High blood pressure ________

Any other condition? Please list: ______________________________

SOCIAL HISTORY: Do you use alcohol? How frequently? ______________________

Do you use tobacco? How frequently? ______________________

Do you use illicit drugs? Please list: ______________________

Occupation and highest level of education completed: ______________________

NAME ______________________ DATE ______________________ hhc 12-12

REVIEW OF SYSTEMS:

GENERAL

Question			
Any **recent** weight changes?	No	Yes	________
Have you **recently** felt more tired / loss of energy?	No	Yes	________
Have you been in poor health most of your life?	No	Yes	________

SKIN

Question			
Any **recent** skin infections or excessive dryness?	No	Yes	________
Any **new** hair growth / **change** in hair growth?	No	Yes	________
Any excessive sweating?	No	Yes	________

HEENT

Question			
Headaches?	No	Yes	________
Difficulty swallowing?	No	Yes	________
Any change in appearance of face?	No	Yes	________
Dry mouth? Excessively thirsty?	No	Yes	________

NECK

Question			
Any lumps, swelling, or enlarging of neck?	No	Yes	________
Any enlarged glands?	No	Yes	________

ENDOCRINE

Question			
Any known thyroid problem?	No	Yes	________
Any recent hormone therapy?	No	Yes	________
Are you bothered by cold or warm temperature?	No	Yes	________
Any history of infertility?	No	Yes	________

RESPIRATORY

Question			
Any difficulty breathing?	No	Yes	________

CARDIOVASCULAR

Question			
Any palpitations?	No	Yes	________
Any recent onset of chest pain?	No	Yes	________
Swelling of hands, feet, or ankles?	No	Yes	________

GASTROINTESTINAL

Question			
Frequent diarrhea or constipation?	No	Yes	________
Cramping or abdominal pain?	No	Yes	________
Recent change in bowel habits?	No	Yes	________

GENITOURINARY

Question			
Frequent urination?	No	Yes	________
Kidney stones?	No	Yes	________
Recent change in menstrual cycles?	No	Yes	________

MUSCULOSKELETAL

Question			
Any weakness of muscles or joints?	No	Yes	________
Difficulty walking?	No	Yes	________
Any change in glove/ring size recently	No	Yes	________

NEURO-PSYCHIATRIC

Question			
Feeling anxious or depressed?	No	Yes	________
Have you had a seizure recently?	No	Yes	________

HEMATOLOGIC

Question			
Are you slow to heal after cuts?	No	Yes	________
Any history of anemia?	No	Yes	________

NAME ____________________ DATE ____________