HEALTH QUESTIONNAIRE

THIS FORM IS MEANT TO ASSIST YOUR DOCTOR IN PROVIDING YOU WITH BETTER HEALTH CARE. IT IS COMPLETELY CONFIDENTIAL AND WILL BE A PART OF YOUR MEDICAL RECORD.
Please circle any questions that you do not understand.

Name: _____ Sex: M F Ht: _____ Wt: _____

Today's Date: _____ Date of Birth: _____ Age: _____

HEALTH HISTORY

CHIEF COMPLAINT: (What brings you in to see the Doctor today?) _____

_____

If cosmetic, what body area(s) are you concerned about? _____

For a specific pain or problem:

Where is it?	
How would you describe it?	
What makes it better or worse?	
When does it occur?	
How severe is it?	
When did it start?	
Duration?	
What other associated symptoms have you been having?	
Did you do anything differently that might have caused you to have these symptoms?	
Have you had any tests or lab work performed to clarify these symptoms? If yes, which one(s)?	

Drug Allergies? Y N
If yes, please list the allergy and your reaction.

MEDICATIONS:Please list all medications and dosages you are currently taking. Include any over the counter medications or herbal preparations.

_____
_____
_____

SURGICAL HISTORY

Have you had any operations, radiation, or chemotherapy? Y N

Operation/Radiation/Chemotherapy	Date Performed	Performing Physician

FAMILY HISTORY

Who, if anyone, in your family has or has had any of the following?

Diabetes		High Blood Pressure	
Heart Disease		Cancer	
Stroke			

SOCIAL HISTORY

Occupation: _____ Full time or Part time? Length of time employed at this job: _____
Marital Status: Single Married Separated Divorced Widowed
Use of Alcohol: Never Rarely Moderate Daily
Use of Tobacco: Never Previously, but quit Current packs per day _____
Use of Illegal/Street Drugs: Never Type/Frequency _____
Are you on any special diet? Y N Type: _____

_____ _____ _____
Patient/Guardian Signature Date Physician Initials

Do you have, or have you ever had any problem related to the following?

Constitutional

Fever	Y	N
Chills	Y	N
Nightsweats	Y	N
Unexplained weight loss	Y	N
Unexplained weight gain	Y	N

Eye

Visual changes	Y	N
Glaucoma	Y	N

Ears, nose, throat

Loss of hearing	Y	N
Sinus problems	Y	N
Frequent sore throats	Y	N
Difficulty breathing	Y	N

Cardiovascular

Heart attack	Y	N
Angina	Y	N
Heart Failure	Y	N
Heart Murmur	Y	N
Mitral Valve Prolapse	Y	N
Abnormal Heart Rhythm	Y	N
High Blood Pressure	Y	N
Stroke/Mini-stroke	Y	N
Aneurysm	Y	N
Poor circulation in legs	Y	N
Raynaud's disease	Y	N
Pacemaker	Y	N
Artificial heart valve implant	Y	N

Respiratory

Asthma	Y	N
Pneumonia	Y	N
Emphysema	Y	N
Bronchitis	Y	N
Tuberculosis	Y	N

Gastrointestinal

Abdominal pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Stomach ulcers	Y	N
Hepatitis	Y	N
Irritable bowel syndrome	Y	N
Blood in stool	Y	N

Genitourinary

Bladder problems	Y	N
Frequent urinary infections	Y	N
Blood in urine	Y	N
Kidney stones	Y	N
Kidney failure	Y	N
Venereal disease	Y	N
Frequent yeast infections	Y	N

Musculoskeletal

Back pain	Y	N
Osteoporosis	Y	N
Arthritis	Y	N
Rheumatoid arthritis	Y	N
Inflammatory disease	Y	N
Artificial joints or prosthesis	Y	N

Integumentary (Skin)/Breast

Skin rash	Y	N
Sore that will not heal	Y	N
Chronic staph infections	Y	N
Breast lump/discharge	Y	N
Breast implants	Y	N

Neurological

Seizures or convulsions	Y	N
Epilepsy	Y	N
Dizzy spells	Y	N
Headaches	Y	N
Head injury	Y	N
Multiple Sclerosis	Y	N

Psychiatric

Depression	Y	N
Manic depression	Y	N
Sleeping disorder	Y	N
Alcoholism	Y	N

Endocrine

Diabetes	Y	N
(please circle type)		
Adult onset		
Juvenile onset		
Insulin dependant		
Non-insulin dependant		
Thyroid dysfunction	Y	N
Gout	Y	N

Allergy/Immunology

Allergic rhinitis	Y	N
Hayfever	Y	N
AIDS or HIV	Y	N
Hepatitis B or C	Y	N

Hematologic/Lymphatic

Anemia	Y	N
Bruise easily	Y	N
Sickle cell disorder	Y	N
Blood clots	Y	N
Enlarged lymph nodes	Y	N
Lupus	Y	N
Excessive bleeding after injury	Y	N

Other

Sensitive to any metals	Y	N
Sensitive to latex	Y	N
Use birth control medications	Y	N

Have you ever taken any of the following drugs?

Fenfluramine	Y	N
Fenfluramine w/ phentermine (fen-phen)	Y	N
Dexfenfluramine (redux)	Y	N
Other weight loss product	Y	N

Please name.

_____