HEALTH QUESTIONNAIRE

First Name _____ Last Name_____ Date of Birth ____/_____/_____

What is the reason for your visit today?_____

_____

_____

Do you have any of the following conditions? Please check those that apply.

AIDS/HIV	❑	Emphysema	❑
Alzheimer's	❑	Hard of hearing	❑
Arthritis	❑	Heart Attack	❑
Asthma	❑	Heart condition	❑
Blood clots	❑	Hepatitis (Type_____)	❑
Cancer	❑ Type_____	High blood pressure	❑
Dementia	❑	High cholesterol	❑
Diabetes	❑	History of falling	❑

Other _____

Have you had surgery before? Please list below.

	When
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Do you use tobacco? ❑ Yes ❑ No What kind? _____ How many?_____ How long?_____

Do you drink alcohol? ❑ Never ❑ Rarely ❑ Moderate ❑ Daily

Do you use recreational drugs? ❑ Never ❑ Rarely ❑ Moderate ❑ Daily What kind?_____

What is your marital status? ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Do you live alone?_____ Do you have a care giver?_____

What are your hobbies? _____

What is your occupation? _____

REVIEW OF SYSTEMS

Are you currently experiencing any of the following conditions? If yes, please check.

Chest pain	_____	Headache	_____
Irregular heart beat	_____	Numbness	_____
Shortness of breath	_____	Tingling	_____
Dizziness	_____	Hair loss	_____
Hearing loss	_____	Rash	_____
Ringing in ears	_____	Skin lesions	_____
Sore throat	_____	Diabetes, good control	_____
Back pain	_____	Diabetes, borderline control	_____
Join pain	_____	Diabetes, poor control	_____
Muscle aches	_____	Diabetes, unknow control	_____
Stiffness	_____	Cold intolerance	_____
Swelling	_____	Excess hunger	_____
Cough	_____	Excessive thirst	_____
Trouble breathing	_____	Frequent urination	_____
Wheezing	_____	Heat intolerance	_____
Good blood pressure	_____	Anxiety	_____
Borderline blood pressure	_____	Depression	_____
Poor blood pressure	_____	Insomnia	_____
Unknown blood pressure	_____	Irritability	_____
Fatigue	_____	Nervousness	_____
Fever	_____	Itching	_____
Night Sweats	_____	Hives	_____
Weakness	_____	Chronic runny nose	_____
Weight loss	_____	Seasonal allergies	_____

Bleeding _____

Bruising _____

Tender nodes _____

Balance problems _____

Pregnancy-1st trimester _____

Pregnancy-2nd trimester _____

Pregnancy-3rd trimester _____