HEALTH QUESTIONNAIRE

Name _____

Date of Birth _____ Age _____ Occupation _____

List all drugs you are currently taking: _____

_____

Are you taking Diuretics (water pills)? _____

Have you taken any aspirin in the last two weeks? Yes ( ) No ( )

Do you smoke? _____

ALLERGIES

Penicillin	Yes ( ) No ( ) Effects _____	Tape	Yes ( ) No ( ) Effects _____
Iodine	Yes ( ) No ( ) Effects _____	Food	Yes ( ) No ( ) Effects _____
Shell Fish	Yes ( ) No ( ) Effects _____	Hay Fever	Yes ( ) No ( ) Effects _____
Other Medicines	Yes ( ) No ( ) Effects _____	Contact Allergy	Yes ( ) No ( ) Effects _____

List all medicine allergies and effects: _____

_____

List all hospitalizations, operations (including plastic surgery) and serious injuries.

Year	Hospitalization/Operation/Injury	Hospital & Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ILLNESS & MEDICAL PROBLEMS

Dizzy Spells	Yes ( ) No ( )	Sickle Cell Trait/Disease	Yes ( ) No ( )	Trouble w/Anesthesia	Yes ( ) No ( )
Glaucoma	Yes ( ) No ( )	Other Eye Problems	Yes ( ) No ( )	Paralysis	Yes ( ) No ( )
Nose Bleeds	Yes ( ) No ( )	Chronic Nose Obstruction	Yes ( ) No ( )	Ear Trouble	Yes ( ) No ( )
Sinus Trouble	Yes ( ) No ( )	Deafness/Hearing Loss	Yes ( ) No ( )	Heart Murmur	Yes ( ) No ( )
Heart Failure	Yes ( ) No ( )	Heart Attack	Yes ( ) No ( )	Other Heart Conditions	Yes ( ) No ( )
Stomach Ulcer	Yes ( ) No ( )	Ankles Swell	Yes ( ) No ( )	Colitis	Yes ( ) No ( )
Swelling Neck	Yes ( ) No ( )	Bronchitis	Yes ( ) No ( )	Asthma	Yes ( ) No ( )
Hiatal Hernia	Yes ( ) No ( )	Diverticulosis	Yes ( ) No ( )	Other Bowel Issues	Yes ( ) No ( )
Emphysema	Yes ( ) No ( )	Trouble Swallowing	Yes ( ) No ( )	Pneumonia	Yes ( ) No ( )
Hepatitis	Yes ( ) No ( )	Tuberculosis	Yes ( ) No ( )	Mononucleosis	Yes ( ) No ( )
Other Lung Issues	Yes ( ) No ( )	Gall Bladder Trouble	Yes ( ) No ( )	Low Blood Pressure	Yes ( ) No ( )
Stroke	Yes ( ) No ( )	Bleed Easily	Yes ( ) No ( )	Convulsion/Seizures	Yes ( ) No ( )
Bruise Easily	Yes ( ) No ( )	Scarlet Fever	Yes ( ) No ( )	Bleeding Disorder	Yes ( ) No ( )
Diabetes	Yes ( ) No ( )	Anemia	Yes ( ) No ( )	High Blood Pressure	Yes ( ) No ( )
Cancer	Yes ( ) No ( )	Chemotherapy	Yes ( ) No ( )	Radiation Therapy	Yes ( ) No ( )
Type of cancer_____		Blood Transfusion	Yes ( ) No ( )	AIDS/HIV	Yes ( ) No ( )

WOMEN ONLY

Tender Breasts	Yes ( ) No ( )	Discharge from Nipples	Yes ( ) No ( )	Lumps/Change in Size	Yes ( ) No ( )
Fibrocystic Disease	Yes ( ) No ( )	Previous Mammogram	Yes ( ) No ( )	Year of Mammogram _____	
Menstrual Problems	Yes ( ) No ( )	Pregnancy	Yes ( ) No ( )	Year of 1st Pregnancy _____	

Were your children breast-fed? Yes ( ) No ( ) Are you or could you be pregnant? Yes ( ) No ( )

FAMILY HISTORY

Tuberculosis	Yes ( ) No ( )	Diabetes	Yes ( ) No ( )	Low Blood Pressure	Yes ( ) No ( )
Asthma	Yes ( ) No ( )	Rheumatoid Arthritis	Yes ( ) No ( )	Bleeding Tendancy	Yes ( ) No ( )
Glaucoma	Yes ( ) No ( )	Heart Disease	Yes ( ) No ( )	Blood Disorders	Yes ( ) No ( )
High Blood Pressure	Yes ( ) No ( )	Cancer	Yes ( ) No ( )		

Relation Type of cancer(s) _____