Health Questionnaire

Patient_____ Date_____

Referring physician_____ DOB_____ Age_____

HT_____ WT_____ BMI_____

Please list prior SURGERY:

_____
_____
_____
_____

ALLERGIES: or [ ] no known allergies

_____
_____
_____
_____

Please list other MEDICAL problems:

- ☐ Diabetes
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Heart Disease
- ☐ Depression
- ☐ Thyroid disease
- ☐ Cancer/tumor
- ☐ Sleep Apnea/Asthma/COPD
- ☐ High blood pressure
- ☐ Bleeding Disorders
- ☐ Stroke
- ☐ Complications with Anesthesia
- ☐ Other:

Current Medications and dosages: or [ ] see attached list

_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY:

Arthritis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Bone disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

Other: _____

SOCIAL HISTORY

Occupation? _____ ☐ Full-time ☐ Part-time ☐ Retired
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Number of children: _____
Alcohol use: ☐ Never ☐ Rare ☐ Moderate ☐ Daily
Smoker: ☐ No ☐ Current ☐ Former
packs / day =____ Quit (year):____
Recreational Substance Use: ☐ Yes ☐ No

Mother: age ____years ☐ healthy ☐ deceased due to:_____
Father: age ____years ☐ healthy ☐ deceased due to:_____

REVIEW OF SYSTEMS: Please fill out CURRENT symptoms only.

Constitutional ☐ Normal
- ☐ Fever/chills
- ☐ Weight loss/gain
- ☐ Poor sleep
- ☐ Poor energy/fatigue

Eyes ☐ Normal
- ☐ Visual loss
- ☐ Blurred/double vision
- ☐ Glaucoma
- ☐ Glasses/contacts

Endocrine ☐ Normal
- ☐ Abnormal hair growth
- ☐ Increased thirst
- ☐ Heat/cold intolerance
- ☐ Increased hat/shoe size

Genitourinary ☐ Normal
- ☐ Incontinence
- ☐ Change in urinary strength
- ☐ Painful urination
- ☐ Blood in urine

Skin ☐ Normal
- ☐ Rash
- ☐ Color change
- ☐ Lumps
- ☐ Hair/nail changes
- ☐ Dryness/itching

Respiratory ☐ Normal
- ☐ Shortness of breath
- ☐ Cough
- ☐ Asthma/bronchitis
- ☐ Painful breathing
- ☐ Tuberculosis

Musculoskeletal ☐ Normal
- ☐ Swelling of joints
- ☐ Stiffness
- ☐ Redness of joints
- ☐ Muscle/joint pain
- ☐ Muscle weakness

Gastrointestinal ☐ Normal
- ☐ Appetite changes
- ☐ Yellowing of skin/eyes
- ☐ Change in bowel habits
- ☐ Heartburn/indigestion
- ☐ Hemorrhoids

Head/neck ☐ Normal
- ☐ Headache
- ☐ Head injury
- ☐ Neck pain/stiffness
- ☐ Swollen glands

Neurological ☐ Normal
- ☐ Numbness/tingling
- ☐ Weakness
- ☐ Seizures
- ☐ Fainting

Cardiovascular ☐ Normal
- ☐ Chest Pain/tightness
- ☐ Leg swelling
- ☐ Arrhythmias
- ☐ Palpitations
- ☐ Easy bruising/bleeding
- ☐ Difficulty breathing lying down

Ear/Nose/Throat ☐ Normal
- ☐ Hearing loss
- ☐ Vertigo/dizziness
- ☐ Nosebleeds
- ☐ Hoarseness

Mental Status ☐ Normal
- ☐ Memory loss
- ☐ Anxiety
- ☐ Sleep disturbances
- ☐ Depression

Patient Signature_____ Date_____ Time _____