TO BE COMPLETED BY PATIENT - PLEASE PRINT

HEALTH QUESTIONNAIRE

REASON FOR VISIT _____

_____

_____

MEDICATIONS	NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN
LIST ALL MEDICATIONS THAT YOU ARE NOW TAKING. INCLUDE OVER THE COUNTER Rx.						
				DRUG ALLERGIES		

MEDICAL HISTORY Mark (C) for current problems. Check (✓) box and indicate age when you had any on the following symptoms or diseases.

- ❑ HEARING PROBLEMS
- ❑ GLAUCOMA ❑ CATARACTS
- ❑ NOSE BLEEDS ❑ SINUS TROUBLE
- ❑ HOARSENESS ❑ HAY FEVER
- ❑ ASTHMA ❑ HYPERTENSION
- ❑ CORONARY HEART DISEASE
- ❑ HEART MURMUR
- ❑ PALPITATIONS ❑ IRREG. PULSE
- ❑ VARICOSE VEINS ❑ PHLEBITIS
- ❑ DIFFICULTY SWALLOWING ❑ HEARTBURN
- ❑ PEPTIC ULCER DISEASE ❑ COLITIS
- ❑ JAUNDICE ❑ HEPATITIS
- ❑ KIDNEY STONES ❑ PROSTATE PROB
- ❑ VENERAL DISEASE ❑ HERPES
- ❑ CHLAMYDIA ❑ GONORRHEA
- ❑ RECENT WEIGHT LOSS
- ❑ ANEMIA ❑ BRUISE EASILY
- ❑ CANCER
- ❑ DIABETES ❑ THYROID DISEASE
- ❑ SEIZURES ❑ STROKE
- ❑ MIGRAINE HEADACHES
- ❑ ARTHRITIS ❑ GOUT
- ❑ MENTAL ILLNESS ❑ DEPRESSION
- ❑ TUBERCULOSIS
- ❑ ALLERGIES (NON DRUG)

ALCOHOL - OZ/WK _____

SMOKING - CIG/DAY _____ # YEARS _____

COFFEE/TEA - CUPS/DAY _____

FEMALES

REGULAR MENSTRUAL PERIODS ❑ YES ❑ NO

NO. OF PREGNANCIES _____

NO. OF LIVE BIRTHS _____

NO. OF MISCARRIAGES _____

BIRTH CONTROL METHOD _____

B.C. PILL (BRAND) _____

MENOPAUSAL SYMPTOMS ❑ YES ❑ NO

SKIN PROBLEMS

- ❑ ECZEMA ❑ PSORIASIS ❑ RASH
- ❑ ABNORMAL MOLES ❑ HIVES
- ❑ FREQUENT SUN EXPOSURES
- ❑ EXCESSIVE SCARRING
- ❑ GYN CANCER
- ❑ RECENT OR PROGRESSIVE HAIR LOSS