

HEALTH QUESTIONNAIRE

DATE COMPLETED: _____

NAME _____ AGE _____ SEX: Male / Female

OCCUPATION _____ EMPLOYER _____

MARITAL STATUS: Single / Married / Divorced / Widowed / Domestic Partner

HEIGHT _____ WEIGHT _____ BIRTHDATE _____ DOMINANT HAND: Left / Right

SPORTS & HOBBIES: _____

NAME OF YOUR PRIMARY CARE PHYSICIAN (INTERNIST OR PEDIATRICIAN): _____

DRUG ALLERGIES: NONE OR LIST: _____

TOBACCO: NEVER SMOKED FORMER SMOKER DATE QUIT?: _____

CURRENT SMOKER # PACKS / PER DAY _____ E-CIGARETTE: YES NO

ALCOHOL: NONE RECOVERING ALCOHOLIC YES, # OF DRINKS PER WEEK _____ / PER MONTH _____

SUBSTANCE/DRUG ABUSE: YES NO PRIOR HISTORY.....PLEASE LIST: _____

In the event an X-Ray is ordered or certain medication is recommended: _____

Are you currently pregnant?: Yes No Date of your last menstrual period: _____

History of: Hysterectomy Menopause Premenopause Postmenopause

PLEASE LIST YOUR CURRENT MEDICATIONS

(Please include over the counter, vitamins/supplements)

Medication(s):

Reason for use of the Medication(s):

1) _____ 6) _____

1) _____ 6) _____

2) _____ 7) _____

2) _____ 7) _____

3) _____ 8) _____

3) _____ 8) _____

4) _____ 9) _____

4) _____ 9) _____

5) _____ 10) _____

5) _____ 10) _____

Pharmacy Name: _____ City/Zip Code: _____

Please list your other physician specialists below.

How were you referred to our practice?

Physician Referral: _____ Tel: _____

Internet Friend/Family

Other: _____

(e.g. Physical Therapist, Home Health Agency, Vendor, Specialists, Walk-in, etc.)

PAST SURGERIES: NONE – OR LIST: (you may use the reverse side for space):

ILLNESSES: NONE – OR LIST:

INJURIES/HOSPITALIZATIONS: NONE – OR LIST: (you may use the reverse side for space):

FAMILY HISTORY: PLEASE CHECK:

Do you or your family have any history of Osteoarthritis (Arthritis) YES NO and/or Osteoporosis YES NO

SYSTEM REVIEW: PLEASE CHECK IF YOU HAVE/HAD ANY OF THESE CONDITIONS:

GENERAL: HEALTHY ILL RECENT WEIGHT GAIN _____ LBS., LOSS _____ LBS.
 PREGNANT

HEART: NORMAL HIGH BLOOD PRESSURE HEART ATTACK ARRHYTHMIA
 HEART FAILURE CORONARY ARTERY DISEASE HIGH CHOLESTEROL

VASCULAR: NORMAL ARTERIAL INSUFFICIENCY VARICOSE VEINS
 CAROTID ARTERY LEG SWELLING PHLEBITIS

LUNGS: NORMAL ASTHMA CHRONIC LUNG DISEASE C.O.P.D.
 BLOOD CLOTS IN LUNG / P.E. PNEUMONIA

GASTROINTESTINAL: NORMAL HEARTBURN / REFLUX PEPTIC ULCER LIVER DISEASE
 HEPATITIS A / B / C OTHER: _____

URINARY TRACT: NORMAL BLADDER INFECTION PROSTATE ENLARGMENT
 FREQUENT URINATION KIDNEY STONES KIDNEY FAILURE

ENDOCRINE: NORMAL DIABETES HYPOTHYROIDISM HYPERTHYROIDISM
 OTHER: _____

HEMATOLOGIC: NORMAL BLOOD CLOTS / D.V.T. ABNORMAL BLEEDING TENDENCIES
 BLOOD TRANSFUSION – (YOUR OWN BLOOD, OR DONOR BLOOD)

NEUROLOGIC: NORMAL STROKE SEIZURES M.S. DEPRESSION

MUSCLES & JOINTS: NORMAL OSTEOARTHRITIS GOUT FIBROMYALGIA
 RHEUMATOID ARTHRITIS OTHER: _____

HEAD & NECK: NORMAL VISUAL LOSS SINUS PROBLEMS HEARING LOSS
 HEADACHE OTHER: _____

SKIN: NORMAL CANCER PSORIASIS ECZEMA RASHES

INFECTIOUS DISEASE: NORMAL HEPATITIS A / B / C HIV TUBERCULOSIS M.R.S.A.

CANCER: NONE YES, TYPE: _____

BONES: NORMAL OSTEOPENIA OSTEOPOROSIS
 FRACTURES, IF YES, WHICH BONES? _____

PLEASE USE THE SPACE BELOW TO EXPLAIN WHY YOU ARE SEEING THE DOCTOR

Date of onset of your current condition: _____
Was your condition caused by an injury? Yes No

SCALE OF PAIN, TODAY: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
(Circle One #) NO PAIN MODERATE WORST PAIN POSSIBLE