

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 \_\_\_\_\_