HEALTH QUESTIONNAIRE

REASON FOR VISIT

Formedic

FAMILY HISTORY

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) Epilepsy	6) Thyroid	11) Osteoporosis	16) High cholesterol
2) Migraine	7) Hayfever	12) Arthritis	17) Alcoholism
3) Mental illness	8) Asthma	13) Heart disease	18) Hepatitis
4) Glaucoma	9) Anemia	14) Stroke	19) Cancer
5) Diabetes	10) Bleeds easily	15) High blood pressure	20)

HOSPITAL ADMISSIONS

not including pregnancies

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING - INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION

ALLERGIES

SUPPLEMENTS

VACCINE — YEAR OF LAST

- Tetanus / Td ____
- Influenza (flu) ____
- Pneumonia ____
- Hepatitis A ____
- Hepatitis B ____
- Whooping C ____

VACCINE — YEAR OF LAST

- MMR Measles / Mumps / Rubella ____
- Meningitis ____
- Chicken pox ____
- HPV ____
- Shingles ____

MEDICAL HISTORY

MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

- ☐ Decreased hearing
- ☐ Ringing in ear
- ☐ Ear infections - *frequent*
- ☐ Dizzy spells ☐ Fainting spells
- ☐ Failing vision ☐ Eye pain
  Date of last eye exam _____
- ☐ Double or blurred vision
- ☐ Nose bleeds ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
  Date of last TB test _____
- ☐ Shortness of breath:
  ☐ on exertion ☐ lying flat
  ☐ in the past week
  ☐ affects work / lifestyle
- ☐ Chest pain ☐ High blood pressure
  Date of last cholesterol test _____
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain - *when walking*
- ☐ Varicose veins / Phlebitis
- ☐ Cold numb feet
- ☐ Loss of appetite - *recent*
- ☐ Difficulty swallowing
- ☐ Heartburn ☐ Peptic ulcer
- ☐ Aspirin - Arthritis - Pain pills
- ☐ Nausea/Vomiting ☐ Gallbladder prob
- ☐ Jaundice / Hepatitis
- ☐ Irritable bowel syndrome
- ☐ Abdominal pain
- ☐ Bloating / discomfort
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's ☐ Colitis
- ☐ Inflammatory bowel disease
- ☐ Bloody or tarry stools
- ☐ Test for blood in stools
- ☐ Hemorrhoids ☐ Hernia

Urination - Overactive Bladder
- ☐ Overnight more than twice
- ☐ More than 8 times / 24 hrs.
- ☐ Urgency to urinate ☐ with leakage
- ☐ Decrease in force/flow ☐ Painful
- ☐ Stress incontinence — urine leakage with exercise / movement
- ☐ Blood in urine ☐ Kidney stones
- ☐ Urine infections - *frequent*
- ☐ Bed wetting
- ☐ Weight loss / gain ☐ Appetite
- ☐ Anemia ☐ Bruise easily
- ☐ Blood transfusions
- ☐ Cancer ☐ Easily fatigued
- ☐ Decreased energy / endurance
- ☐ Diabetes ☐ Thyroid disease
- ☐ Seizures ☐ Stroke
- ☐ Tremor / hands shaking
- ☐ Headaches ☐ Numbness
- ☐ Arthritis / Rheumatism
- ☐ Bone fracture / joint injury
- ☐ Osteoporosis ☐ Back pain
- ☐ Foot pain ☐ Gout
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Concentration problems
- ☐ Depression ☐ Nervousness
- ☐ Agitation ☐ Memory loss
- ☐ Moodiness ☐ Suicidal thoughts
- ☐ Feelings of worthlessness
- ☐ Phobias ☐ Mental illness
- ☐ Sleep problems - how long ____
  How frequent _____
  ☐ Waking refreshed
- ☐ Rheumatic fever ☐ Scarlet fever
- ☐ Chickenpox ☐ Polio ☐ Mumps
- ☐ Measles ☐ German measles
- ☐ Tuberculosis ☐ Herpes
- ☐ Aids / Hiv ☐ Std
- ☐ Sexual problems / enjoyment
- ☐ Decreased life enjoyment
- ☐ Decreased work performance
- ☐ Alcohol _____oz. per week
- ☐ Coffee / Tea _____cups per day
- ☐ Smoking - cig/day___ # years
  year quit ___
- ☐ Exercise _____
- ☐ Street drugs_____
- ☐ Unwanted facial hair

Hair loss: ☐ progressive ☐ recent

MALES - ☐ Prostate problems

FEMALES - *Please complete*

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ Pain / Cramps

Days of flow___ Length of cycle___

Date — 1st day of last period _____

Number of:

Pregnancies ___ Abortions _____

Miscarriages ___ Live births _____

Birth control method_____

B.C. pill (name)_____

- ☐ Flushing / Menopause
- ☐ Pain / Bleeding during or after sex
- ☐ Migraine ☐ with nausea

Date of last Pap test_____

☐ normal ☐ abnormal

Date of last mammogram_____

☐ normal ☐ abnormal

NOTES