

HEALTH QUESTIONNAIRE

Name (Dr. / Mr. / Mrs. / Ms. / Miss) _____ M F Other

Email _____ Mobile # _____

Reason for Visit: PHYSICAL / PAP / WELLNESS / PRE-OP / OTHER _____ Date of Birth: _____

Current prescriptions and/or supplements: _____

Allergies (to meds): NONE / _____

PAST MEDICAL & SURGICAL HISTORY

Please check if YOU have been diagnosed with the following conditions:

- Measles / Mumps Asthma / COPD High blood pressure Sleep apnea / CPAP Hepatitis / Cirrhosis
- Chickenpox Diabetes / Prediab High Cholesterol Chronic insomnia STDs / STIs
- Birth defects Arthritis / Gout Heart attacks / Stents / CABG Rheumatic fever Herpes 1 / 2
- GERD Strokes / Seizures Irreg heartbeat / A fib / Pacemaker / Defibrillator Tuberculosis
- Thyroid disorder Neuropathy Chronic pain _____ Anxiety / Depression Rheumatic fever
- Wear Glasses / Contacts Glaucoma / Cataracts Wear hearing aids Wear dentures Have dental impants
- Cancer Details: _____
- Injuries / Disability / Broken bones Details: _____
- Car accident(s) & details: _____
- Hospitalization(s) Details: _____
- Anesthesia Local Regional General Other / Unknown Details: _____
- Operations: Tonsils / Appendix / Hysterectomy / Vasectomy / Cosmetic Details: _____
- Other serious conditions & details: _____

FAMILY HISTORY

Please check if any blood relative has ever had:

- Breast cancer _____ Colon cancer _____ Other cancers _____
- Mental illness (anxiety / depression / bipolar / other) _____
- Bleeding tendencies Osteoarthritis / Gout Asthma / COPD / Emphysema Smoker? Y / N
- Diabetes / Prediabetes Dementia / Alzheimer's Seizures / Epilepsy Strokes
- Heart disease - heart attacks / stents / bypass surgery High blood pressure High cholesterol
- Tuberculosis Other _____

RELATIVE	AGE	HEALTH ISSUES	AGE & CAUSE OF DEATH
Father			
Mother			
Sibling(s)			
iii M/F			
iii M/F			
Spouse			
Children			
iii M/F			
iii M/F			

SOCIAL HISTORY

Marital Status: Single Married Separated Divorced Widowed Other _____
Sexually active? Yes No If yes, with males with females both Sex life satisfactory? Yes No
Feel safe at home? Yes No Are you living with your spouse/partner/other? Yes No
Dependents at home? Yes No Children / Grandchildren / Pets / Other _____
Do you drink alcohol? Yes No Details: _____
Do you smoke / vape? Yes No Details: _____
Have you ever smoked / vaped? Yes No Details: _____
Do you use drugs? Yes No Details: _____
Regular exercise? Yes No _____ Healthy Diet? Yes No Do you have an Advance Directive? Yes No
Hobbies or what you like to do to relax: _____
Employment: Full-time Part-time Unemployed / Retired Student Details: _____
Time lost due to health reasons: In the past 6 mos? _____ past yr: _____ past 5 yrs: _____

REVIEW OF SYSTEMS

Please **CIRCLE** if you have or have had any of the following in the **PAST 2 WEEKS**:

GENERAL: Fever Chills Fatigue Weight loss Weight gain Appetite loss/increase Can't sleep Feeling sad/blue Stressed out
SKIN: Itchy Dry Acne Jaundice Hives Eczema Psoriasis Rashes Boils Abnormal pigmentation
HEAD and NECK: Headaches Ear disease Eye disease/injury Double vision Blurry vision Glaucoma Cataracts Itchy eyes
Poor hearing Dizziness Runny nose Sneezing Nosebleeds Sinus trouble Sore throat Mouth sores Stiff neck Enlarged glands
RESPIRATORY: Frequent colds Spitting up blood Cough Wheezing Difficulty breathing Shortness of breath Painful breathing
Pleurisy Pneumonia History of Tb History of COVID Snoring Daytime sleepiness Wake up unrefreshed from sleep
CVS: Chest pain Shortness of breath at rest / with activity Awakening in night smothering Difficulty walking two blocks
Swelling of hands / feet / ankles High blood pressure High cholesterol Heart murmur Valvular heart disease Palpitations
DIGESTIVE SYSTEM: Food sticks in throat Heartburn/Indigestion Ulcer Nausea Vomiting Vomiting blood Gallbladder ds
Liver trouble Cramping Gas/Bloating Diarrhea Constipation Painful stools Hemorrhoids Bloody stools Black stools
GYNECOLOGICAL: Age periods started: _____ Periods come every _____ days Lasting _____ days Flow is light / med / heavy
Last period _____ Painful periods Irregular periods PMS Last Pap _____ HPV history? Y / N
of pregnancies _____ # of abortions/miscarriages _____ Cesarean section Birth control _____
Peri-menopause / Menopause _____ Hysterectomy _____ Fibroids _____ Took hormones? Y / N
Last mammogram _____ Dense breast tissue? Y / N Vaginal / Bladder prolapse Vaginal / Urethral discharge
GENITOURINARY: Circumcised? Y / N Kidney stones Leaky urine Frequent urination Burning/painful urination Blood in urine
Testicular pain / swelling Enlarged prostate Testosterone replacement therapy Last PSA _____
MUSCULOSKELETAL: Falls Balance / Walking Problems Varicose veins Weakness of muscles or joints Pain or swelling of joints
Upper / Mid / Lower Back pain Scoliosis Pain in buttock/calves while walking, relieved with rest Leg / ankle swelling
ENDOCRINE: Thyroid disease Change in hat/glove size Hair loss Always hot / cold Dry skin Coarse hair Hot flashes
Ideal desired weight _____ Current weight _____ Current height _____
HEMATOLOGIC: Slow healing Easy bruising Anemia Phlebitis Blood Clots Had a blood transfusion Cancer _____
NEUROPSYCHIATRIC: Lightheadedness Fainting spells Numbness Tingling Paralysis Weakness Convulsions / Seizures
Disinterest in usual activities Hopelessness Worthlessness Suicidal Poor concentration Memory Loss Anorexia Bulimia

PREVENTIVE

Most recent vaccination: TDAP / Tetanus _____ Flu _____ COVID _____ Pneumonia _____
Shingles (2 doses) _____ RSV _____ I CHOOSE TO NOT VACCINATE _____
Last blood test _____ Last colonoscopy _____ Bone density _____
Eye exam _____ Hearing test _____ Dentist visit _____
Hep C _____ Elective body MRI _____ Elective Coronary Artery Calcium Scan _____

Patient's signature: _____ Date: _____

Reviewed by: _____ / ANN MAI, M.D Date: _____