

HEALTH QUESTIONNAIRE – PAGE 2

PATIENT NAME: _____

PHYSICAL HABITS

Can you run up a flight of stairs? yes no

Can you walk up a flight of stairs? yes no

How far can you walk? _____

Which sports do you participate in and how often? _____

Any other physical activity, i.e. yard work, housework? yes no If yes, what? _____

SOCIAL HISTORY

Do you drink alcohol? yes no If yes, how often? _____

Do you smoke? yes no If yes, how much? _____

Do you, or have you ever, used street drugs? yes no If yes, in the past week? yes no

PERSONAL HISTORY

What is the most you have ever weighed? _____ Your weight one year ago? _____

When was your last chest xray? _____ Where? _____

When was your last EKG? _____ Where? _____

FAMILY HISTORY

Have any of your family members had any of the following?

Diabetes Heart Trouble Hypertension Bleeding Problems

Colon Cancer Breast Cancer Gallstones

Other Hereditary or Contagious Diseases If yes, what? _____

FEMALE ONLY

Date of last menstrual period _____

Are you pregnant? yes no If yes, number of months _____

Number of pregnancies _____ Births _____ Other _____

SYSTEMS REVIEW

Please check the following disease or symptoms you have or have had in the past:

- | | | |
|--|---|--|
| <input type="checkbox"/> Eye or Ear Disease | <input type="checkbox"/> Nose or Throat Disease | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Concussion/Head Injury | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Convulsions or Epilepsy | <input type="checkbox"/> Polio or Meningitis | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Spitting Up Blood |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Angina Pectoris |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Heart Flutter | <input type="checkbox"/> Swelling of Hands/Feet |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Colitis/Bowel Disease | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis or Rheumatism |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Recent Appetite Change | <input type="checkbox"/> Neuritis or Neuralgia |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hives | <input type="checkbox"/> Poisoning |

Explanation of above, if necessary _____

PATIENT SIGNATURE: _____ DATE _____