

HEALTH QUESTIONNAIRE

Date _____

A. Patient Information

First Name: _____ Last Name: _____ M.I.: _____

Address: _____ City, State, Zip: _____ Home phone #: _____

Email Address: _____ Cell phone #: _____

Sex: Male Date of birth: _____ Age: _____ S.S.#: _____ D.L. #: _____

Female Weight _____ Height _____

Occupation: _____ Employed by: _____ Work phone #: _____

Work address: _____ City, State, Zip: _____

Marital status single married widowed divorced other

Patient resides with: lives alone spouse parents children

Children: yes no How many? _____

Spouse's name: _____ Spouse's phone #: _____

Spouse's Date of Birth: _____ SS #: _____ Spouse's employer/occupation: _____

Race: Caucasian Black Hispanic Asian American Indian Other

Who referred you to our office? _____

Emergency Contact: _____ Phone #: _____

B. Review of Systems – Do you currently have any of the following?

- | | | | |
|--|--|---|--|
| 1. <u>Skin</u> | <input type="checkbox"/> normal | 4. <u>Reproductive</u> | <input type="checkbox"/> normal |
| <input type="checkbox"/> rash | <input type="checkbox"/> bruise easily | Male only: | Female only: |
| <input type="checkbox"/> redness | <input type="checkbox"/> dryness | <input type="checkbox"/> testical pain | <input type="checkbox"/> painful menstruation |
| <input type="checkbox"/> itching | <input type="checkbox"/> nail changes | <input type="checkbox"/> prostate problems | <input type="checkbox"/> breast lump/mass |
| <input type="checkbox"/> hair changes | <input type="checkbox"/> other | <input type="checkbox"/> infertility | <input type="checkbox"/> breast dimpling/discharge |
| 2. <u>Nervous System</u> | <input type="checkbox"/> normal | <input type="checkbox"/> impotence | <input type="checkbox"/> abnormal vaginal bleeding |
| <input type="checkbox"/> paralysis | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> other | <input type="checkbox"/> abnormal periods |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> memory loss | 5. <u>Cardiovascular\Pulmonary</u> | <input type="checkbox"/> normal |
| <input type="checkbox"/> headache | <input type="checkbox"/> anxiety | <input type="checkbox"/> chest pain | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> tremors | <input type="checkbox"/> depression | <input type="checkbox"/> palpitations | <input type="checkbox"/> coughing up blood |
| <input type="checkbox"/> seizures | <input type="checkbox"/> mood swings | <input type="checkbox"/> coughing | <input type="checkbox"/> swollen extremities |
| <input type="checkbox"/> weakness | <input type="checkbox"/> other | <input type="checkbox"/> wheezing | <input type="checkbox"/> other |
| 3. <u>Special Senses</u> | <input type="checkbox"/> normal | <input type="checkbox"/> murmur | |
| <input type="checkbox"/> vision problems | <input type="checkbox"/> ringing ears | 6. <u>Digestive</u> | <input type="checkbox"/> normal |
| <input type="checkbox"/> hearing loss | <input type="checkbox"/> loss of touch sensation | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> sinus problem | <input type="checkbox"/> nausea | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> loss of taste | <input type="checkbox"/> loss of smell | <input type="checkbox"/> vomiting | <input type="checkbox"/> ulcer |
| <input type="checkbox"/> other | | <input type="checkbox"/> constipation | <input type="checkbox"/> other |
| | | 7. <u>Urinary</u> | <input type="checkbox"/> normal |
| | | <input type="checkbox"/> painful urination | <input type="checkbox"/> inability to hold urine |
| | | <input type="checkbox"/> frequent urination | <input type="checkbox"/> kidney stones |
| | | <input type="checkbox"/> bladder infections | <input type="checkbox"/> other |

Doctor's Notes

6. WOMEN ONLY:

DOCTOR'S NOTES

To your knowledge are you pregnant? Y ____ N ____

Last OB-GYN exam: _____

Dr. name: _____

7. Do you currently have or previously had any of the following?

- allergies
- asthma
- cancer
- dislocated joints
- HIV
- high blood pressure
- herniated disc
- heart trouble
- multiple sclerosis
- polio
- pacemaker
- STD
- stroke
- surgical implants
- arthritis
- broken bone/fracture
- diabetes
- AIDS
- epilepsy
- hardening of arteries
- kidney trouble
- joint replacement
- osteoporosis
- prostate trouble
- mental/emotional
- scoliosis
- thyroid

8. Any other conditions or information you would like us to know?

How will you be paying today? Check ____ Cash ____ Credit Card ____ Other ____

Patient Signature: _____ Date: _____

Authorization to Release Records to Patient's Insurance Carrier:

Patient Signature: _____ Date: _____