Name _____
Social Security # _____
Medical Record # _____
Date: _____

HEALTH QUESTIONNAIRE

Chief Complaint: *(Reason, symptoms, condition or diagnosis that prompts your appointment)*

_____

_____

Past Medical History:

Do you have a history of any of the following conditions or diseases?

	Circle Yes or No		Details of "Yes" response
Cardiovascular			
Heart attack	**Yes**	**No**	_____
Heart failure	**Yes**	**No**	_____
Pacemaker	**Yes**	**No**	_____
Irregular heart beat	**Yes**	**No**	_____
Heart valve disease	**Yes**	**No**	_____
Artificial heart valve	**Yes**	**No**	_____
Rheumatic fever	**Yes**	**No**	_____
Shortness of breath	**Yes**	**No**	_____
Hypertension *(high blood pressure)*	**Yes**	**No**	_____
Musculoskeletal			
Artificial joints	**Yes**	**No**	_____
Rheumatoid arthritis	**Yes**	**No**	_____
Skin	**Yes**	**No**	_____
Healing problems	**Yes**	**No**	_____
Keloid scars	**Yes**	**No**	_____
Surgical complications	**Yes**	**No**	_____
Skin cancer	**Yes**	**No**	_____

Continued on the other side

Neurologic

Stroke **Yes** **No** _____

Seizure disorder **Yes** **No** _____

Hematologic

Bleeding problems **Yes** **No** _____

Anemia **Yes** **No** _____

Eyes

Glaucoma **Yes** **No** _____

Ear, nose, and throat

Hearing difficulty **Yes** **No** _____

Gum disease **Yes** **No** _____

Sinus disease **Yes** **No** _____

Respiratory

Asthma **Yes** **No** _____

Emphysema **Yes** **No** _____

Psychiatric

Severe anxiety **Yes** **No** _____

Depression **Yes** **No** _____

Psychosis **Yes** **No** _____

Allergic/Immunologic

AIDS/HIV infection **Yes** **No** _____

Cancer (other than skin) **Yes** **No** _____

Gastrointestinal

Hepatitis **Yes** **No** _____

Liver disease **Yes** **No** _____

Diabetes **Yes** **No** _____

Genitourinary

Kidney disease **Yes** **No** _____

Bladder problem **Yes** **No** _____

Name_____ Social Security # ---------- _____
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Date _____

Are You Presently Having Any of the Following Symptoms or Problems?

Constitutional

Fever	**Yes**	**No**
Weight loss	**Yes**	**No**
Fatigue	**Yes**	**No**
Night sweats	**Yes**	**No**

Eyes

Tearing	**Yes**	**No**
Burning	**Yes**	**No**

Ear, Nose, Throat

Bleeding	**Yes**	**No**
New growths	**Yes**	**No**

Respiratory

Cough	**Yes**	**No**
Shortness of breath	**Yes**	**No**

Cardiovascular

Chest Pain	**Yes**	**No**
Leg swelling	**Yes**	**No**
Leg pain with exercise	**Yes**	**No**

Gastrointestinal

Abdominal pain	**Yes**	**No**
Nausea/vomiting	**Yes**	**No**
Blood in stools	**Yes**	**No**
Black, tarry stools	**Yes**	**No**

Genitourinary

Bleeding	**Yes**	**No**
New growths	**Yes**	**No**

Musculoskeletal

Bone pain	**Yes**	**No**

Lymphatic

Enlarged lymph nodes	**Yes**	**No**

Neurological

Pain, burning, numbness	**Yes**	**No**
Headache	**Yes**	**No**
Weakness	**Yes**	**No**

Medications

Please list your medications, including dosages: _____

Are you allergic to any medications, Latex, or Iodine?
If yes, please list to what and explain your reaction. _____

Do you take aspirin?
If yes, when was last dose? _____

Continued on the other side

Do you take coumadin? **Yes** **No**

If yes, when was last dose? _____

Do you take Vitamin E? **Yes** **No**

If yes, when was last dose? _____

Do you take Motrin, Advil, Aleve, or similar anti-inflammatory medicines? **Yes** **No**

If yes, when was last dose? _____

Have you had an organ transplant? **Yes** **No**

If yes, what organ and why? _____

Have you been advised to take antibiotics before surgery? **Yes** **No**

If yes, why? Which antibiotic? _____

Social History

Are you employed? **Yes** **No**

If yes, do you perform any strenuous work? **Yes** **No**

Do you use tobacco? **Yes** **No**

If yes, what kind? _____

If cigarettes, how many packs per day? _____

Do you use alcohol? **Yes** **No**

If yes, what is amount and frequency? _____

Family History

Is your father alive? **Yes** **No** If no, cause of death _____

Is your mother alive? **Yes** **No** If no, cause of death _____

Has anyone in your immediate family had melanoma? **Yes** **No**

If yes, what relative? _____

Has anyone in your family had other forms of skin cancer? **Yes** **No**