HEALTH QUESTIONNAIRE

NAME ________________ AGE ________ DATE ____________
ADDRESS ________________________ PHONE ____________

HISTORY OF PAST ILLNESS: Have you had:

Childhood:

Measles........ No Yes
Mumps........ No Yes
Chickenpox........ No Yes
Diabetes........ No Yes
Strokes........ No Yes
Cancer........ No Yes
Tuberculosis........ No Yes
Venereal disease. .No Yes
Rheumatic fever or heart disease. .... No Yes
Congenital Abnormalities........ No Yes
Other serious diseases........ No Yes

Adult:

Have you had any serious illness?........ No Yes
Have you ever been hospitalized or been under medical care for very long?........ No Yes
If yes, for what reason?________________

Operations:

Have you had any surgery? .... No Yes
List ________________
____
____

Injuries:

Have you had any broken bones? .... No Yes
Have you had any head concussions or injuries? .... No Yes
Have you ever been knocked unconscious ? .... No Yes

IMMUNIZATION	No	Yes	Year
Measles			
Mumps			
Flu			
Tetanus			
Pneumonia			

FAMILY HISTORY:	If Living: Age	Health	If Deceased: Age (at death) & Cause		Has any blood relative ever had:		
Father					Cancer	No	Yes
Mother					Tuberculosis	No	Yes
Brother / Sister					Diabetes	No	Yes
					Heart touble	No	Yes
					High bood pressure	No	Yes
					Stroke	No	Yes
Husband/ Wife					Convulsions	No	Yes
Son / Daughter					Suicide	No	Yes
					Mental illness	No	Yes
					Bleeding tendency	No	Yes
					Gout or other arthritis	No	Yes
					Hereditary defects	No	Yes

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed

Are you living with your husband or wife?........ No Yes
Is your sex life satisfactory? .... No Yes
Do you have dependents at home?........ No Yes
Alcoholic Beverages: Never____ Rarely____ Moderately____ Daily____ Ever?____ No Yes
Tobacco: Cigarettes ____ Packs a day____ Don't smoke____ Ever smoked? No Yes
Are you employed? Full Time____ Part Time____
What is your job?________________
Are you exposed to fumes, dust or solvents?________________
Education: (Years)
Grade School ____ High School ____ College____ Postgraduate____

How much time have you lost from work because of your health during the past?
Six Months ____ One Year____ Five Years____

SYSTEMIC REVIEW: Do you have any of the following?

General:

Recent weight change?........ No yes
Have you been in good general health most of your life?........ No Yes

Skin:

Skin Disease........ No Yes
Hives, eczema or rash........ No Yes
Frequent infection or boils........ No Yes
Abnormal pigmentation........ No yes

Head-Eyes-Ears-Nose:

Eye disease or injury. .... No yes
Do you wear glasses? .... No Yes
Double vision .... No yes
Headaches........ No Yes
Glaucoma........ No Yes
Itching eyes or nose........ No Yes

Head-Eves-Ears-Nose-Throat (con'd)

Sneezing or runny nose........ No Yes
Nosebleeds........ No Yes
Chronic sinus trouble........ No Yes
Ear disease........ No Yes
Impaired hearing .... No Yes
Dizziness or transient episodes of unconsciousness........ No Yes

Neck:

Stiffness........ No Yes
Thyroid trouble........ No Yes
Enlarged glands........ No Yes

Respiratory:

URI (cold) now .... No Yes
Spitting up blood........ No Yes
Chronic or frequent cough .... No yes