HEALTH QUESTIONNAIRE

Please complete this questionnaire so that we can serve your health needs. NOTE: This is confidential information that will not be released to any person except when you have authorized us to do so. Please use back side if you need more space.

Name: **Age:** **Date of Birth:**

☐Single ☐Divorced ☐Married ☐Widowed

Date of last physical examination:
Occupation:

Ethnicity: please circle
Spanish/Hispanic or non Spanish/hispanic

Today's date:

Primary Language: **Race:**

Vision or Hearing impaired?

Email address:

Past Surgeries/Hospitalizations (give details-dates and reasons):

____
____
____
____
____
____
____

List all **medications**, dose and frequency presently being taken (including birth control pills and vitamins):

1.______________________________
2.______________________________
3.______________________________
4.______________________________
5.______________________________
6.______________________________
7.______________________________
8. ______________________________
9. ______________________________

Is your Mother alive? If not, what age did she pass and of what?
____

Is your Father alive? If not, what age did he pass and of what?
____

Health problems of any of your siblings?______________________
____
____

What **specialty doctors** do you see and for what problem?
____
____
____
____
____
____
____

Emergency contact name and #
____
____

Date of last Tetanus shot:
____

Allergies (circle all that apply):

Latex Dyes/Iodine
Penicillin Bees/Wasps
Sulfa Codeine/Morphine
Tetanus Mycin
Aspirin Foods
Other:________________

Past Medical History (Circle all that apply)

Illnesses:

Aids/HIV Disease
Allergies, Hay fever
Anemia or any bleeding disorders

Bone or joint disease
Arthritis or Rheumatism
Broken bones, Dislocations
Bursitis, Sciatica or Lumbago
Sprains/strains
Gout
Polio

Asthma
Tuberculosis
Pleurisy
Pneumonia
Bronchitis
Emphysema

Colitis or other bowel disease
Gallbladder disease
Hepatitis or jaundice
Hemorrhoids or any rectal disease

Concussion
Epilepsy/Seizures
Migraine Headaches
Meningitis

Bladder disease or any urinary Tract disease
Gonorrhea, Syphilis, Chlamydia, Herpes or other sexually transmitted disease
Kidney disease

Heart Disease
High or low blood pressure
Rheumatic Fever or Heart disease

Lacerations
Hives or Eczema
Frequent infections or boils

Measles, German Measles, Mumps
Small Pox
Chicken Pox

Influenza (flu)
Cancer
Diabetes
Glaucoma/Cataracts
Food, Chemical, or drug poisoning

Other diseases __________________

Comments:

Social History (Circle appropriate answer):

Do you smoke?Yes No Have you ever?YesNo

How many packs per day?______________

For how many years?___________________
Do you drink alcohol? Yes No
If so how much per day/week?____________

Have you ever taken any recreational drugs? (i.e. "pot", cocaine, crack, etc) Yes No
Are you sexually active? Yes No

Type of birth control used?______________

Have you ever been abused? Yes No

If yes, when?__________________________

For Women Only:

Age when your periods started?_______

How many pregnancies?___ Miscarriages:__

Abortions:____________

Date of your last period?________________

Date of your last pap smear?_____________

Date of last mammogram?________________

Who is your Gynecologist?_______________