HEALTH QUESTIONNAIRE

sansum CLINIC

MRN: _____
Name: _____
D.O.B. _____

DATE____/____/____ **Phone** ( )_____ **Age**____ **Referring person or physician**_____
What is/are your chief symptom(s) or medical problem(s) at this time? _____

_____

_____

SURGICAL HISTORY: ☐ **NONE**

Operation Reason Date

_____
_____
_____
_____
_____
_____
_____
_____

Surgical/Anesthetic Complications? ☐ Yes ☐ No
Blood Transfusions? ☐ No ☐ Yes; Dates? _____

MEDICAL HISTORY: ☐ **NONE**

Please list any significant medical illness (high blood pressure, diabetes, cancer, etc.) or injuries (fractures, etc.) Hospitalized?

_____ ☐
_____ ☐
_____ ☐
_____ ☐
_____ ☐

IMMUNIZATION HISTORY (DATES):

Tetanus _____ Measles, Mumps, Rubella
Pneumonia _____ _____
Influenza _____ Hepatitis A _____
Polio_____ Hepatitis B _____

FAMILY HISTORY:

Please indicate the health problems of your relatives:

RELATIVE	Age	Health Problem(s) (Or Cause of Death)	Age at Death
FATHER			
MOTHER			
BROTHER(S)			
SISTER(S)			
CHILDREN			
OTHERS			

ALLERGIES: ☐ **NONE**

Medications Reactions

_____
_____
_____

Others (Food, Bee Stings, etc.): _____
_____

MEDICATIONS NOW BEING TAKEN: ☐ **NONE**

(Include vitamins, eye drops, Aspirin, Tylenol and other non-prescription drugs) ***PLEASE BRING ALL MEDICATIONS***

MEDICATION	DOSE	FREQUENCY

SOCIAL HISTORY:

Birthplace: _____
Marital Status: ☐single ☐married ☐widowed ☐divorced ☐separated
How long? _____
Children: #_____ Ages: _____
With whom do you live? _____
Education: _____
Occupation(s) (past & present) _____
_____
Have you traveled outside the USA in the past year? ☐ No
☐ Yes Where and when? _____
_____
Religion (optional) _____
What form of exercise do you get? _____
_____ hours/wk _____
Hobbies & interest _____
_____

HABITS:

Smoking/Tobacco_____ packs/day for # of _____years
What year did you quit?_____
Alcohol average #_____drinks/day for # of _____years
What year did you quit?_____
Caffeine:_____cups per day. ☐ Coffee ☐ Tea ☐ Cola
Do you (or have you) used other drugs? ☐ No ☐ Yes
Other: _____
_____
_____

I. GENERAL **(LEAVE THIS SECTION BLANK)**

1. Are you frequently ill? ☐ Yes ☐ No
2. Are you having ☐ fever ☐ chills ☐ sweats? ☐ Yes ☐ No
3. Have you ☐ lost ☐ gained weight in the last year? ☐ Yes ☐ No
4. What is the most you have ever weighed? Pounds _____
5. Do you have a loss of appetite? ☐ Yes ☐ No
6. Do you have difficulty with ☐ falling asleep ☐ staying asleep ☐ loud snoring ☐ need for daytime sleep? ☐ Yes ☐ No
7. Do you find yourself falling asleep when ☐ it is not intended or ☐ dangerous? ☐ Yes ☐ No
8. Do your legs jerk frequently or feel restless ☐ before or ☐ during sleep? ☐ Yes ☐ No
9. Are you having difficulty experiencing pleasure? ☐ Yes ☐ No
10. Have you ever had an ☐ emotional illness or ☐ experienced prolonged periods of an unexplained sadness or ☐ frequent mood swings? ☐ Yes ☐ No
11. Do you have feelings of worthlessness or guilt? ☐ Yes ☐ No
12. Do you have difficulty concentrating? ☐ Yes ☐ No
13. Do you experience intrusive or unwanted thoughts or feel a need to do unnecessary tasks? ☐ Yes ☐ No
14. Do you have recurrent thoughts of death? ☐ Yes ☐ No
15. Are you considered a nervous person? ☐ Yes ☐ No
16. Have you ever felt you should cut down your alcohol consumption? ☐ Yes ☐ No

17 Was there a period when you consumed more alcohol than you do now? ☐ Yes ☐ No

18. Do people annoy you by criticizing your drinking? ☐ Yes ☐ No
19. Are you in a relationship in which you have been ☐ threatened or ☐ physically abused by your partner? ☐ Yes ☐ No
20. Has your partner ever prevented you from ☐ leaving the house, ☐ seeing friends, ☐ getting a job, or ☐ continuting your education? ☐ Yes ☐ No
21. Do you wear seat belts? ☐ Yes ☐ No
22. Do you need help with ☐ shopping, ☐ preparing meals, ☐ housework, ☐ laundry, ☐ managing your medications? If yes, please describe:_____ ☐ Yes ☐ No
23. Does your home have rugs in the hallway? ☐ Yes ☐ No
24. Does your home lack grab bars in the bathroom? ☐ Yes ☐ No
25. Does your home lack handrails on the stairs? ☐ Yes ☐ No
26. Does your home have poor lighting? ☐ Yes ☐ No
27. Are there any personal problems you would like to discuss (e.g. ☐ family problems, ☐ concerns about HIV/AIDS, ☐ preventive health issues)? ☐ Yes ☐ No
28. Are you on disability? ☐ Yes ☐ No
29. Is litigation pending regarding a medical problem? ☐ Yes ☐ No
30. When was your last complete physical exam? 20_____
31. Do you have a current Advanced Directive(e.g. Durable Power of Attorney for Health Care, etc.)? ☐ Yes ☐ No
32. If you have an Advanced Directive, who holds this document? _____

II. SKIN

33. Have you had a ☐ skin rash or ☐ itching? ☐ Yes ☐ No
34. Have you ever had ☐ lumps, or ☐ growths, or ☐ changing moles? ☐ Yes ☐ No
35. Have you had significant changes in ☐ hair, ☐ nails? ☐ Yes ☐ No
36. Do you have a history of skin cancer? ☐ Yes ☐ No
37. Have you experienced skin reactions to the sun (photosensitivity) other than sunburn? ☐ Yes ☐ No

III. EYES

38. Have you had ☐ double vision, ☐ blurry vision, or ☐ blind spots? ☐ Yes ☐ No

(LEAVE THIS SECTION BLANK)

39. Do you wear ☐ glasses or ☐ contact lenses? ☐ Yes ☐ No
40. Do you have ☐ glaucoma or ☐ cataracts? ☐ Yes ☐ No
41. Have you had ☐ surgery or ☐ laser treatment to your eyes? ☐ Yes ☐ No
42. Have you had any ☐ eye injuries or ☐ infections? ☐ Yes ☐ No
43. When was you last eye examination? 20_____

IV. EARS

44. Do you have any current ear problems? ☐ Yes ☐ No
45. Are you hard of hearing? ☐ Yes ☐ No
46. Do you have ringing in the ears? ☐ Yes ☐ No
47. Have you been exposed to loud noises? ☐ Yes ☐ No
48. Do others feel your are hard of hearing? ☐ Yes ☐ No
49. When war you last hearing test? 20_____

V. NOSE AND THROAT

50. Have you had sinus trouble? ☐ Yes ☐ No
51. Do you have any ☐ hay fever or ☐ seasonal allergies? ☐ Yes ☐ No
52. Have you had ☐ hoarseness ☐ or change in voice? ☐ Yes ☐ No
53. Are you troubled by nosebleeds? ☐ Yes ☐ No
54. Do you have alteration in ☐ taste or ☐ smell? ☐ Yes ☐ No
55. Do you have nasal polyps? ☐ Yes ☐ No
56. Have you had any history of radiation treatments to the face or neck? ☐ Yes ☐ No
57. Do you have any history of thyroid diseases? ☐ Yes ☐ No

VI. CHEST

58. Have you had ☐ asthma or ☐ wheezing? ☐ Yes ☐ No
59. Do you have shortness of breath ☐ at rest, ☐ with exertion or ☐ at night ☐ Yes ☐ No
60. Do you have a frequent cough? ☐ Yes ☐ No
61. Do you cough up any discolored mucus? ☐ Yes ☐ No
62. Have you been exposed to asbestos? ☐ Yes ☐ No
63. Have you experienced ☐ itching, ☐ congestion, or ☐ trouble breathing when exposed to latex or rubber products? ☐ Yes ☐ No
64. When was your last TB skin test? 20_____
65. When was you last chest X-Ray? 20_____

VII. HEART

66. Do you have high blood pressure? ☐ Yes ☐ No
67. Do you have elevated cholesterol level? ☐ Yes ☐ No
68. Do you have ☐ chest pain, ☐ or discomfort? ☐ Yes ☐ No
69. Are your ankles often swollen? ☐ Yes ☐ No
71. Do you have heart problems? ☐ Yes ☐ No
71. Have you had a heart attack? 20_____
72. Do you have a ☐ heart murmur, ☐ abnormal valve, ☐ congested heart failure, ☐ heart enlargement, ☐ irregular heart beating, or ☐ arrhythmia? ☐ Yes ☐ No
73. When was your last EKG? 20_____
74. When was your last Treadmill? 20_____
75. When was you last Angiogram? 20_____

VIII. GASTROINTESTINAL

76. Do you have trouble swallowing? ☐ Yes ☐ No
77. Do you regularly have heartburn? ☐ Yes ☐ No
78. Are you troubled by ☐ nausea or ☐ vomiting? ☐ Yes ☐ No
79. Are you troubled by abdominal pain? ☐ Yes ☐ No
80. Have you ever been diagnosed as having an ☐ ulcer or ☐ gallbladder disease? ☐ Yes ☐ No
81. Have you had any ☐ liver or ☐ pancreas problems? ☐ Yes ☐ No
82. Have you ever had ☐ hepatitis or ☐ jaundice? ☐ Yes ☐ No
83. Do you have ☐ diarrhea or ☐ constipation? ☐ Yes ☐ No
84. Do you have ☐ hemorrhoids, ☐ other rectal problems? ☐ Yes ☐ No
85. Have you had ☐ black or ☐ bloody stools? ☐ Yes ☐ No

(LEAVE THIS SECTION BLANK)

86. Have you been diagnosed as having colon polyps? ☐ Yes ☐ No
87. Do you use laxatives? ☐ Yes ☐ No
    Names of laxatives:_____
88. When was you last proctoscopic/sigmoidoscopic exam? 20_____

IX. GENITOURINARY

89. Have you ever been bothered by frequent urination? ☐ Yes ☐ No
90. How many times do you urinate at night?_____times ☐ Yes ☐ No
91. Do you have burning pain while urinating? ☐ Yes ☐ No
92. Have you had a recent kidney or bladder infection? ☐ Yes ☐ No
93. Have you passed blood in your urine? ☐ Yes ☐ No
89. Have you ever had a kidney stone? ☐ Yes ☐ No
94. Do you have trouble starting or stopping urination? ☐ Yes ☐ No
95. Do you loose control of your bladder at times? ☐ Yes ☐ No
96. Have you ever had a venereal disease? ☐ Yes ☐ No
    Type(s)_____
97. Are you having any sexual problems? ☐ Yes ☐ No
98. (Men) Do you have a history of prostrate trouble? ☐ Yes ☐ No

X. GYNECOLOGICAL

99. When was your last mammogram? ☐ Yes ☐ No
100. Was your last mammogram normal ☐ or abnormal ☐? ☐ Yes ☐ No
101. When was your last Pap smear? ☐ Yes ☐ No
102. Was your last Pap smear ☐ normal or ☐ abnormal? ☐ Yes ☐ No
103. Are you having hot flashes? ☐ Yes ☐ No
104. When was your last menstrual period? ____/____/____
105. Form of birth control used:_____
106. Number of pregnancies? _____
107. Weight of heaviest baby? _____lbs. _____oz.
108. Do you have any ☐ vaginal pain or ☐ discharge? ☐ Yes ☐ No
109. Do you have vaginal bleeding other than with a normal menstrual period? ☐ Yes ☐ No
110. Are your periods painful? ☐ Yes ☐ No
111. Do you have ☐ breast pain, ☐ lumps, ☐ discharge? ☐ Yes ☐ No
112. Have you ever taken estrogen therapy? ☐ Yes ☐ No
113. Did you mother take DES (a hormone) while pregnant with you? ☐ Yes ☐ No

XI. BONES AND JOINTS

114. Do you have ☐ joint pain or ☐ stiffness? ☐ Yes ☐ No
115. Do your joints ever get ☐ red or ☐ swollen? ☐ Yes ☐ No
116. Do you have back pain that limits your activity? ☐ Yes ☐ No
117. Do you have severe neck pain? ☐ Yes ☐ No
118. Have you ever had gout? ☐ Yes ☐ No
119. Do you have osteoporosis? ☐ Yes ☐ No
    Date of last osteoporosis scan?_____
120. Do you have ☐ muscle weakness or ☐ tenderness? ☐ Yes ☐ No
121. Do you get muscle cramps with ☐ walking or ☐ at night? ☐ Yes ☐ No
122. Have you lost height? ☐ Yes ☐ No

XII. NEUROLOGICAL

123. Are you ☐ RIGHT or ☐ LEFT handed? ☐ Yes ☐ No
124. Are you having ☐ frequent or ☐ severe headaches? ☐ Yes ☐ No
125. Have you ever had ☐ fainting or ☐ loss of consciousness? ☐ Yes ☐ No
126. Have you ever had a seizure or convulsion (epilepsy)? ☐ Yes ☐ No
127. Are you ever bothered by a spinning sensation (vertigo)? ☐ Yes ☐ No
128. Do you have balance problems? ☐ Yes ☐ No
129. Do you have periods of lightheadness? ☐ Yes ☐ No
130. Do you experience ☐ numbness or ☐ tingling in your ☐ arms or ☐ legs? ☐ Yes ☐ No

Name of Patient/signature of Person Completing this Form

Physician Signature / Date