Health Maintenance contin... Name: ____________________

When, if ever, did you last have any of the following:

________	Cholesterol check	________	Pap Smear
________	Colonoscopy	________	Prostate exam
________	EKG/Cardiogram	________	Tetanus (Last shot)
________	Flu Vaccine	________	Treadmill stress test
________	Mammogram		

Social History

Are you married? **Yes / No**

Do you have children / dependents at home? **Yes / No** *How many?* ________

Are you employed? **Yes / No** *What field?* ________

What is your highest level of education? ____________________

Do you or have you ever smoked or chewed tobbacco? **Yes / No**

Packs per day ________ */ yrs* ______ *Quit?* ________ *When?* ____________

Do you or have you ever used illegal drugs? **Yes / No** *Type:* ____________

Do you drink alcohol? **Yes / No** *How much per week?* ________

Have you been exposed to toxic substances? **Yes / No** *What?* ____________

Do you drink caffeine daily? **Yes / No** *How much?* ____________

Do you exercise regularly? **Yes / No** *Type?* ____________

Do you wear seat belts? **Yes / No**

Do you use car seats for your children if under 60lbs.? **Yes / No**

Do you have a living will or advance directives? **Yes / No**

Review of Symptoms

Please circle any of the following that you experience.

General	Fatigue Fever Hopelessness Hot flashes Insomnia Night sweats Poor concentration Recent weight loss or gain Loss of interest in usual activities
Skin	Change in pigmentation Eczema Hives Jaundice Rashes
ENT	Change in vision / hearing Dizziness Englarged glands Glaucoma Headaches Hearing loss Neck stiffness Nose bleeds Chronic sinus or ear problems
Respiratory	Asthma Difficulty breathing Frequent colds / coughing Shortness of breath Spitting up blood.
Cardiac	Angina Chest pain Difficulty walking 2 blocks Heart murmur High blood pressure Palpitations Swelling of hands / feet
Gastrointestinal	Abdominal pain /cramping Blood or dark stool Change in bowel habits Frequent diarrhea Frequent indigestion / heartburn / gas / bloating Hepatitis Hemorrhoids Vomiting blood
Genitourinary	Difficulty urinating Frequent urination Loss of bladder control Unsatisfactory sex life
Musculoskeletal	Joint pain or swelling Difficulty walking Muscle cramping or weakness Varicose veins
Neuropsychiatric	Prior treatment for depression / psychiatric care? Fainting spells Paralysis Convulsions
Hematologic	Easy bruising Excessive bleeding after cuts Slowing healing after cuts

HEALTH QUESTIONNAIRE

Name: ______________________ Date: ______________

Birthdate: ______________________

Medications

Please list any medications that you currently take regularly (including non-prescription) ______________

____

Allergies

Please list any allergies to medications, foods or other ______________________

____

Medical History

Illnesses/Conditions

Do you have or have you ever had any of the following:

	Condition	Year
____	Anemia	____
____	Anxiety	____
____	Arthritis	____
____	Asthma	____
____	Birth Defects	____
____	Cancer (type:)	____
____	Colitis	____
____	Concussion	____
____	Depression	____
____	Diabetes	____
____	Emphysema	____
____	Heart Attack/Heart Disease	____
____	High Blood Pressure	____
____	High Cholesterol	____
____	Kidney Disease	____
____	Liver Disease	____
____	Low Blood Sugar	____
____	Mitral Valve Prolapse/Murmur	____
____	Osteoporosis	____
____	Pneumonia	____
____	Rheumatic Fever	____
____	Seizure Disorder	____
____	Sexually Transmitted Disease	____
____	Stroke	____
____	Thyroid Disorder	____
____	Tuberculosis	____
____	Ulcer	____

Surgical Procedures/Hospitalizations	Year
______________	____
______________	____
______________	____
______________	____

Serious Injuries

______________	____
______________	____
______________	____

Childhood Diseases

	Disease	Year
____	Chickenpox	____
____	Measles	____
____	Mumps	____
____	Polio	____
____	Other: ________	____

Gynecological History (women only)

Are you pregnant?	______
Are you breast feeding?	______
Last menstrual period	______
How many pregnancies have you had?	______
How many children do you have?	______
At what age did you start having periods?	______

Family History

Has any blood relative ever had any of the following :

	Relative (mother, father, sister, etc.)
Bleeding problems	
Cancer (type)	
Convulsions	
Diabetes	
Heart Attack	
Heart Disease	
High Blood Pressure	
Mental Illness / Suicide	
Seizures	
Stroke	
Other	

	Living Age	Deceased Age (at death) & cause
Father		
Mother		
Brother / Sister		
Husband / Wife		
Son / Daughter		

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