# CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

**This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask our receptionist, and we will be happy to have our Patient Services Representative help you.**

Your Name: ______________________________ Date: __________

Address: ______________________________

City: ______________ State: __________ Zip: __________

Home Phone #: __________ Pager: __________ Cell Ph: __________

Age: ______ Date of Birth: ________ SS#: __________ E-mail: __________

Marital Status: ☐M ☐ S ☐ D ☐ W Drivers License # __________

Your Occupation: ______________ Employed by: ______________

Phone #: ______________ Address: ______________

Is your visit due to an accident? ☐ Yes / ☐ No

**Are you are Medicare Patient? ☐ Yes / ☐ No Medicare #: __________**

Your Spouse's Name: ______________________________

Spouse's Employer: ______________ Spouse's work phone #: ______________

Name of person to contact in case of emergency: ______________

Their home and work phone number: ______________

Name of nearest relative not living with you: ______________

Their phone number: ______________

Who referred you to this office so we may thank them? ______________

Referring Physician: ______________

In order to determine if care can be of benefit to you, this office will extend the courtesy of an initial consultation without charge. If the doctor might be able to help you with your condition, are you interested in seeking care? ☐ Yes ☐ Unsure

**THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT.**

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

Patient's Signature: ______________________________ Date __________

Parent or Guardian: ______________________________

Signature: ______________________________ Date __________

## FAMILY HISTORY List any of the diseases listed above which run in your family.

| Relative | Age if Living | Age at Death | Cause of Death | State of Health | Illnesses |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brother(s) | | | | | |
| Sister(s) | | | | | |
| Maternal Grandfather | | | | | |
| Maternal Grandmother | | | | | |
| Paternal Grandfather | | | | | |
| Paternal Grandmother | | | | | |

## SOCIAL HISTORY Check the boxes and fill in.

Current Weight ____________ Have you recently lost or gained weight? ____________________

Mental Work ☐ Heavy ☐ Moderate ☐ Light Hours per day ____________

Physical Work ☐ Heavy ☐ Moderate ☐ Light Hours per day ____________

Exercise ☐ Heavy ☐ Moderate ☐ Light Hours per week ____________ Type ____________________

Smoking ☐ Current ☐ Previous Packs/Day ______ No. of years ______

Alcohol Beer/Week ______ Liquor/Week ______ Wine/Week ______ No. of Years ______

Caffeine (*Coffee, Tea, Cola*) Cups/Day ______ No. of Years ______

Aspirin No./Day ______ No. of Years ______ Others ____________________

**MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:**

Aches ^^^^ Numbness oooo Pins/Needles •••• Stabbing ////

**MARK AN "X" ON THE LINES:**

How bad are your symptoms now?

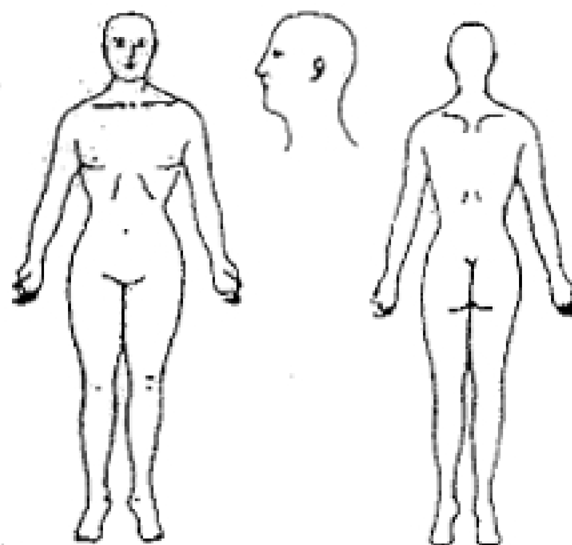
----------------------------------------

None Most Severe

How bad have they been in the past?

----------------------------------------

None Most Severe



Patient Name______________________ Number __________ Date __________

| NEUROLOGIC | NOW | PAST |
|---|---|---|
| Seizures | ☐ | ☐ |
| Vertigo | ☐ | ☐ |
| Dizziness | ☐ | ☐ |
| Hand Trembling | ☐ | ☐ |
| Loss of Sensation | ☐ | ☐ |
| Incoordination | ☐ | ☐ |
| Loss of Facial | ☐ | ☐ |
| Week Grip | ☐ | ☐ |
| Paralysis | ☐ | ☐ |
| Difficulty Speech | ☐ | ☐ |
| Tingling | ☐ | ☐ |
| Loss of Memory | ☐ | ☐ |
| Numbness | ☐ | ☐ |

| ENDOCRINE | NOW | PAST |
|---|---|---|
| Weight Loss | ☐ | ☐ |
| Weight Gain | ☐ | ☐ |
| Extremely Thin | ☐ | ☐ |
| Heat Intolerance | ☐ | ☐ |
| Cold Intolerance | ☐ | ☐ |
| Hair Changes | ☐ | ☐ |
| Breast Changes | ☐ | ☐ |

| IMMUNIZATION/VACCINATION | |
|---|---|
| DPT | ☐ |
| Mumps | ☐ |
| Smallpox | ☐ |
| Typhoid | ☐ |
| Tetanus | ☐ |
| Measles | ☐ |
| Pneumococcal | ☐ |
| Influenza | ☐ |
| Polio | ☐ |
| MMR | ☐ |

**BLOOD TYPE**

| | | | |
|---|---|---|---|
| A + | ☐ | A - | ☐ |
| B + | ☐ | B - | ☐ |
| AB + | ☐ | AB - | ☐ |
| O + | ☐ | O - | ☐ |

Other ____________

**BLOOD TRANSFUSIONS**

Date________________

Date________________

Date________________

Date________________

| PSYCHIATRIC | NOW | PAST |
|---|---|---|
| Hyperventilation | ☐ | ☐ |
| Insecurity | ☐ | ☐ |
| Depression | ☐ | ☐ |
| Troubled Sleep | ☐ | ☐ |
| Irritable | ☐ | ☐ |
| Undecidedness | ☐ | ☐ |
| Timid | ☐ | ☐ |
| Hallucinations | ☐ | ☐ |
| Loss of Memory | ☐ | ☐ |
| Alcoholism | ☐ | ☐ |
| Drug Addiction | ☐ | ☐ |
| Drug Dependent | ☐ | ☐ |
| Suicidal Thoughts | ☐ | ☐ |
| Extreme Worry | ☐ | ☐ |
| Sexual Problems | ☐ | ☐ |

| MUSCULOSKELETAL | NOW | PAST |
|---|---|---|
| Muscle Pain | ☐ | ☐ |
| Muscle Weakness | ☐ | ☐ |
| Muscle Cramps | ☐ | ☐ |
| Muscle Twitching | ☐ | ☐ |
| Joint Stiffness | ☐ | ☐ |
| Joint Pain | ☐ | ☐ |

**PAST MEDICAL HISTORY. Check only the ones you have had in the past.**

| | | | |
|---|---|---|---|
| Hay Fever | ☐ | Epilepsy | ☐ |
| Mumps | ☐ | Paralysis | ☐ |
| Rheumatic Fever | ☐ | Polio | ☐ |
| Allergies | ☐ | Mental Illness | ☐ |
| Angina | ☐ | Alcoholism | ☐ |
| Cancer | ☐ | Depression | ☐ |
| Tumor | ☐ | Nervous Breakdown | ☐ |
| Blood Disease | ☐ | Migraine | ☐ |
| Leukemia | ☐ | Gout | ☐ |
| Heart Trouble | ☐ | Hemorrhoids | ☐ |
| Varicose Veins | ☐ | Prostate Problems | ☐ |
| Phlebitis | ☐ | Sexual Problems | ☐ |
| Hypertension | ☐ | Gonorrhea | ☐ |
| Stroke | ☐ | Syphilis | ☐ |
| Ulcers | ☐ | Diabetes | ☐ |
| Jaundice | ☐ | Bladder Trouble | ☐ |
| Skin Trouble | ☐ | Kidney Stones | ☐ |
| Gallstones | ☐ | Kidney Infections | ☐ |
| Liver Trouble | ☐ | Diabetes | ☐ |
| Hepatitis | ☐ | Bladder Trouble | ☐ |
| Parasites | ☐ | Dysentery | ☐ |

Date of Last Chest X-Ray ____________ ☐ Normal ☐ Abnormal

Last TB Skin Test ____________ ☐ Normal ☐ Abnormal

Allergies: ________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

Patient Name______________________ Number __________ Date __________

**REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.**

| GENERAL | NOW | PAST |
|---|---|---|
| Weakness | ☐ | ☐ |
| Fatigue | ☐ | ☐ |
| Fever | ☐ | ☐ |
| Chills | ☐ | ☐ |
| Night Sweats | ☐ | ☐ |
| Fainting | ☐ | ☐ |
| **SKIN** | | |
| Color Changes | ☐ | ☐ |
| Nail Changes | ☐ | ☐ |
| Hair Changes | ☐ | ☐ |
| Moles | ☐ | ☐ |
| Rashes | ☐ | ☐ |
| Sores | ☐ | ☐ |
| Weakness | ☐ | ☐ |
| **HEAD** | | |
| Headaches | ☐ | ☐ |
| Injuries | ☐ | ☐ |
| Bumps | ☐ | ☐ |
| Last Eye Exam ______ | | |
| Glasses | ☐ | ☐ |
| Contacts | ☐ | ☐ |
| Cataracts | ☐ | ☐ |
| **EARS** | | |
| Hard of Hearing | ☐ | ☐ |
| Deafness | ☐ | ☐ |
| Ringing | ☐ | ☐ |
| Discharge | ☐ | ☐ |
| Earache | ☐ | ☐ |
| Itching | ☐ | ☐ |
| Dizziness | ☐ | ☐ |
| Room Spins | ☐ | ☐ |
| **NOSE** | | |
| Decreased Smell | ☐ | ☐ |
| Bleeding | ☐ | ☐ |
| Pain | ☐ | ☐ |
| Discharge | ☐ | ☐ |
| Obstruction | ☐ | ☐ |
| Post Nasal Drip | ☐ | ☐ |
| Deviated Septum | ☐ | ☐ |
| Runny Nose | ☐ | ☐ |
| Sinus Congestion | ☐ | ☐ |
| **MOUTH** | | |
| Bleeding Gums | ☐ | ☐ |
| Sores | ☐ | ☐ |
| Dental Problems | ☐ | ☐ |
| Bad Breath | ☐ | ☐ |
| Loss of Taste | ☐ | ☐ |
| Dry Mouth | ☐ | ☐ |
| Ulcers | ☐ | ☐ |
| Blisters | ☐ | ☐ |

| THROAT | NOW | PAST |
|---|---|---|
| Soreness | ☐ | ☐ |
| Bad Tonsils | ☐ | ☐ |
| Hoarseness | ☐ | ☐ |
| Pain | ☐ | ☐ |
| Trouble Swallowing | ☐ | ☐ |
| Recurrent Infections | ☐ | ☐ |
| **NECK** | | |
| Neck Enlargement | ☐ | ☐ |
| Stiff Neck | ☐ | ☐ |
| Soreness | ☐ | ☐ |
| Lumps | ☐ | ☐ |
| Masses | ☐ | ☐ |
| **BREASTS** | | |
| Discharge | ☐ | ☐ |
| Lumps | ☐ | ☐ |
| Pain | ☐ | ☐ |
| Bleeding | ☐ | ☐ |
| Nipple Changes | ☐ | ☐ |
| Skin Changes | ☐ | ☐ |
| Bloated | ☐ | ☐ |
| **LUNGS** | | |
| Cough | ☐ | ☐ |
| Phlegm | ☐ | ☐ |
| Blood | ☐ | ☐ |
| Short of Breath | ☐ | ☐ |
| Wheezing | ☐ | ☐ |
| Pain | ☐ | ☐ |
| Congestion | ☐ | ☐ |
| Inhalant Exposure | ☐ | ☐ |
| **HEART** | | |
| Murmur | ☐ | ☐ |
| Palpitations | ☐ | ☐ |
| Rapid Heartbeat | ☐ | ☐ |
| Swollen Extremities | ☐ | ☐ |
| Cold Extremities | ☐ | ☐ |
| Chest Pain/Pressure | ☐ | ☐ |
| Varicose Veins | ☐ | ☐ |
| Blood Clots | ☐ | ☐ |
| Blue Extremities | ☐ | ☐ |
| **BLOOD** | | |
| Anemia | ☐ | ☐ |
| Low Blood Iron | ☐ | ☐ |
| Easy Bruising | ☐ | ☐ |
| Easy Bleeding | ☐ | ☐ |
| Swollen Nodes | ☐ | ☐ |
| Painful Nodes | ☐ | ☐ |
| Sugar in Blood | ☐ | ☐ |
| Red Spots | ☐ | ☐ |

| GASTROINTESTINAL | NOW | PAST |
|---|---|---|
| Abdominal Pain | ☐ | ☐ |
| Nausea | ☐ | ☐ |
| Bloated | ☐ | ☐ |
| Belching | ☐ | ☐ |
| Heartburn | ☐ | ☐ |
| Indigestion | ☐ | ☐ |
| Irregular Bowel Habits | ☐ | ☐ |
| Constipation | ☐ | ☐ |
| Diarrhea | ☐ | ☐ |
| Gas | ☐ | ☐ |
| Hemorrhoids | ☐ | ☐ |
| Poor Appetite | ☐ | ☐ |
| Food Intolerance | ☐ | ☐ |
| Bloody Stools | ☐ | ☐ |
| Black Stools | ☐ | ☐ |
| **GENITOURINARY** | | |
| Urgency | ☐ | ☐ |
| Incontinence | ☐ | ☐ |
| Straining | ☐ | ☐ |
| Back Pain | ☐ | ☐ |
| Frequent Voiding | ☐ | ☐ |
| Stones | ☐ | ☐ |
| Burning | ☐ | ☐ |
| Bed Wetting | ☐ | ☐ |
| Small Stream | ☐ | ☐ |
| Discharge | ☐ | ☐ |
| Impotence | ☐ | ☐ |
| Dribbling | ☐ | ☐ |
| Cloudy Urine | ☐ | ☐ |
| Urine Color ______ | | |
| Spotting Between Periods | ☐ | ☐ |
| Menstrual Cramps | ☐ | ☐ |
| Discharge | ☐ | ☐ |
| Itching | ☐ | ☐ |
| Painful Intercourse | ☐ | ☐ |
| Irregular Periods | ☐ | ☐ |
| Hot Flashes | ☐ | ☐ |

Contraception Type ______

Age at First Period ______

Duration of Cycle ______

Duration of Flow ______

No. of Pregnancies ______

No. of Births ______

No. of Miscarriages ______

No. of Abortions ______

Menstrual Flow ☐ Heavy ☐ Mod ☐ Light

Last Period ______

Last Pap Smear ______

Last Vaginal Exam ______

Last Mammogram ______

Last Prostate Exam ______

**NAME** ______________________

Patient Name ______________________ Number ____________ Date ________