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The Science of Health. The Art of Care.

Internal Medicine Health Questionnaire

TODAY'S DATE: _____

NAME_____BIRTHDATE_____

Please complete and bring this in for you r appointment. This information allows us to do a more complete review of your health and give you a better evaluation and advice. Please mark each question either "Yes" or "No" if at all possible. If uncertain how to answer it, put a question mark (?) after it. If a question doesn't apply to you, write "NA" next to it. Brief notes may be written in the margin. You may have a copy of this, on request, for your records.

CHIEF PROBLEM: REASON FOR TODAY'S VISIT

_____

_____

_____

WHEN WAS YOU LAST COMPLETE PHYSICAL OR BLOOD WORK DONE? RESULT?

_____

_____

PAST HISTORY: LIST ALL SIGNIFICANT ILLNESS, OPERATION, INJURIES, HOSPITAL STAYS

YEAR	ILLNESS/OPERATION	COMMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MARK "YES" IF YOU EVER HAD ANY OF THE FOLLOWING:

Measles	Yes/No	HIV testing	Yes/No	Cancer	Yes/No	Alcohol problem	Yes/No
Mumps	Yes/ No	Tuberculosis	Yes/No	Venereal Disease	Yes/No	Illicit Drugs	Yes/No
Chicken Pox	Yes/No	Pos. TB Test	Yes/No	Pelvic Infection	Yes/No	Victim of abuse	Yes/No
Diphtheria (Whooping cough	Yes/No	High blood pressure	Yes/No	Chronic back pain	Yes/No	Victim of violence	Yes/No
Polio	Yes/No	Heart Disease	Yes/No	Blood Clots	Yes/No	Hepatitis	Yes/No
Rheumatic fever	Yes/No	High Cholesterol	Yes/No	Diabetes	Yes/No	Abnormal PAP	Yes/No

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MEDICATIONS WHAT MEDICATION ARE YOU NOW TAKING? (Don't forget such things as aspirin, cortisone, blood pressure pills, nerve pills, hormones, birth control, laxatives, vitamins, herbs, and supplements-ANYTHING you use)

MEDICINE	DOSE	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HAVE YOU TAKEN AN ANTIBIOTIC IN THE PAST THREE (3) MONTHS? _____

DO YOU HAVE ANY FOOD ALLERGIES OR GET ASTHMA OR HIVES FROM FOOD? _____

ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS OR TO IODINE XRAY DYE? YES NO

DRUG	WHAT REACTION DID YOU HAVE?	WHEN:
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY: If living: age/health If decreased, age at death; cause; main problems with health

Father: _____

Mother: _____

Brothers: _____

Sisters: _____

Husband/wife/partner:_____

Sons: _____

Daughter: _____

Have any blood relatives ever had:			List Whom?
Cancer:	Yes	No	_____Type: _____
Diabetes:	Yes	No	_____
Heart trouble	Yes	No	_____
Stroke:	Yes	No	_____
High blood pressure:	Yes	No	_____
Migraine:	Yes	No	_____
Suicide, mental disorder	Yes	No	_____
Bleeding tendency	Yes	No	_____
Alcohol Problem	Yes	No	_____
Serious Osteoporosis	Yes	No	_____

SOCIAL HISTORY: ARE YOU Single Married Separated Divorced Widowed Living with partner

Who do you share your home with? Spouse or Partner Children: _____ Other: _____

Does your spouse or partner have serious health problems? No Yes: _____

How is your relationship with spouse or partner? (1=major problem, 5= wonderful): 1 2 3 4 5 _____

How is your Sex Life? (1=major problem, 5=wonderful): 1 2 3 4 5 about how many lifetime sex partners? _____

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SOCIAL HISTORY CONT.

How is your relationship with the children? (1=major problems, 5=wonderful): 1 2 3 4 5 _____

What is your occupation? _____ Work hours per week? _____

Highest education level: high school or less college graduate or professional school

What is your stress level like recently (1=minimal, 10=major/burnout) in:

WORK: _____ HOME LIFE: _____ FINANCIAL: _____ HEALTH: _____ OTHER: _____

Do you smoke? No Yes If YES, how much? ____per month Did you ever smoke: No Yes At what age did you begin? _____

How many cups of coffee do you drink a day? ____ cups Cans of cola? ____ Glasses of milk? _____

How much alcohol do you typically drink? (kind, average amount in a day, week or month) _____

Did you ever drink considerably more than what you wrote here? No Yes:_____

Is anyone after you to stop drinking or get counseling? No Yes: _____

Calcium: Do you have milk, yogurt, and cheese daily; or use supplement? No Yes: _____

Fiber: Typical portions daily of fruit, vegetables, coarse grains? 0-2 3-5 5-7 more_____

Do you always wear seatbelts when you drive? No Yes

How many days per week do you exercise at least ½ hour? _____

IMMUNIZATIONS: Have you had the basic shots for:

Diphtheria (whooping cough) and tetanus (DPT or DT) No Yes Booster past 10 years? Yes _____ No

Polio (3 oral Sabin or Salk injections with booster: No Yes

Mumps vaccine No Yes Measles Vaccine No Yes Chicken Pox vaccine No Yes Rubella vaccine No Yes

Hepatitis B vaccine No Yes Hepatitis A Vaccine No Yes Pneumovax (Pneumonia vaccine) No Yes

DO YOU USUALLY TAKE INFLUENZA FLU SHOTS? No Yes

SYSTEM REVIEW- GENERAL

Do you eat a well-balanced diet? No Yes

Approx. weight 5 years ago _____ 6 months ago _____ Now _____ Your height is _____

Do your miss much time from work? If YES, what from? No Yes

HAVE YOU EVER HAD OR DO YOU NOW HAVE?

HEAD

Eye disease or injury	No	Yes	
Double Vision	No	Yes	
Headaches (circle as applies) Rare Occasionally Frequent Constant Minor Moderate Severe Migraine			
Glaucoma	No	Yes	Last time tested? _____
Itching eyes or nose, hay fever	No	Yes	
Nosebleeds	No	Yes	
Sinus Trouble	No	Yes	
Ear Disease	No	Yes	
Hearing Trouble	No	Yes	
Ringing in ears	No	Yes	
Severe dizziness, passing out	No	Yes	

HEAD CONT.

Seizures, convulsions, epilepsy	No	Yes
Numbness or paralysis	No	Yes
TIA or stroke	No	Yes

NECK & THYROID

Thyroid ailment over or under active?	No	Yes
Gland enlargement	No	Yes
Injury, arthritis, surgery or chiropractic	No	Yes

RESPIRATORY, CHEST

Spitting of blood,	No	Yes
Chronic cough (including smokers' cough)	No	Yes
Do you cough up phlegm every day?	No	Yes
Asthma or wheezing	No	Yes If yes, worse with: dusts exercise, animal hair, nighttime stress?
Shortness of breath	No	Yes

How many blocks can you walk without having to stop to catch your breath? _____

Severe sweating during the night	No	Yes
Last chest x-ray_____ OK?	No	Yes
Last TB skin test?	Never	Yes: _____ Results normal? Yes No

CARDIOVASCULAR

Chest pressure, pain, angina?	No	Yes
Short of breath in bed at night?	No	Yes
Any heart troubles?	No	Yes
Ankles often badly swollen	No	Yes
Heart murmur	No	Yes
Rapid, hard or skipped heart beats	No	Yes
Last EKG cardiogram? _____ Normal?	No	Yes
Every had a treadmill or cardiac stress test	No	Yes
Ever had an angiogram	No	Yes
Told to use antibiotics for dental care	No	Yes

DIGESTIVE

Peptic ulcer when? _____	No	Yes
Heartburn or indigestion	No	Yes
Sour taste in mouth or throat often	No	Yes
Often use Tums, Rolaids, Maalox, any antacid	No	Yes
Poor tolerance to spicy foods, coffee, alcohol	No	Yes
Do foods stick in throat while swallowing	No	Yes
Gallbladder trouble	No	Yes
Ever vomited blood	No	Yes
Poor tolerance to greasy food or fat	No	Yes
Liver trouble, jaundice, hepatitis	No	Yes

Crampy abdominal pain often	No	Yes
Chronic constipation	No	Yes
Frequent diarrhea	No	Yes
Change in bowel habits	No	Yes
Hemorrhoids or piles	No	Yes

GENITOURINARY

Loss of urine when cough or sneeze	No	Yes
Kidney or bladder infection	No	Yes
Burning or painful urination	No	Yes
Frequent urination	No	Yes
Do you have to get up at night to urinate?	No	Yes
Strong urgency almost lose control	No	Yes
Blood in urine	No	Yes
Kidney Stones	No	Yes
Swelling of hands and feet	No	Yes
Difficulty starting urination/weak stream	No	Yes

GYNECOLOGICAL (WOMEN ONLY)

Age periods started_____years old, Frequency: every _____days Last period was: _____ Is PMS a problem for you?

Periods: Regular and normal No Yes If No, how are they abnormal? _____

Menopause? Age_____ Are there symptoms it caused? _____ any vaginal bleeding since menopause? _____

Number of pregnancies? _____ Deliveries? _____ Complications? _____

Date of last Pap smear _____ Normal Abnormal: _____

Frequent vaginal discharge	No	Yes
Ever had fibroids, endometriosis, and cysts?	No	Yes
Do you do breast self- exam regularly?	No	Yes
Any previous breast biopsy	No	Yes

MUSCULOSKELTAL

Bothersome arthritis	No	Yes
Weakness which is new or limits activity	No	Yes
Difficulty in walking	No	Yes
Varicose veins	No	Yes
Pain in calves or buttocks on walking	No	Yes
Any gout in past?	No	Yes

SKIN

Frequent infections	No	Yes
Skin disorder (what type)	No	Yes
Skin cancer removed. Moles removed?	No	Yes
Do you use sunscreen routinely in sun?	No	Yes

EMOTIONAL

Do you have much trouble sleeping?	No	Yes
Are you tired most of the time?	No	Yes
Are you often depressed or distracted?	No	Yes
Do you have trouble with temper, anger?	No	Yes
Are you often anxious?	No	Yes
Are you a nervous person?	No	Yes
Do you get physically sick when stressed?	No	Yes
Do you constantly worry about your health?	No	Yes
Have you ever been advised to, or been under Psychiatric care or psychotherapy?	No	Yes

HEMATOLOGIC/BLOOD-TRANSMITTED DISEASE

Have you ever been anemic? When?	No	Yes
Excessive bleeding or abnormal bruising?	No	Yes
Did you ever receive blood products?	No	Yes
Did you ever shoot drugs by needle or share needle?	No	Yes
Have you had a same-sex partner in past 10 years?	No	Yes
Do you use condoms routinely with new sexual partners?	No	Yes

Circle YES if you are UNABLE to do any of the following:

Read	No	Yes
Bathe yourself	No	Yes
Do own shopping	No	Yes
Manage own checkbook	No	Yes
Walk without assistance	No	Yes
Drive	No	Yes

DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTHCARE?	No	Yes
Did someone other than the patient help fill out this form?	No	Yes

WHOM? _____

WHAT OTHER HEALTH CONCERNS DID YOU WANT TO DISCUSS?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____