

HEALTH QUESTIONNAIRE

PAST MEDICAL AND SURGICAL HISTORY:

Do you have any medical conditions or illnesses? Please list:

Have you had any operations? Please list:

Females: What age did you start menstrual cycles? ____ Do you have irregular cycles? ____
Did you have diabetes during pregnancy or any children born heavier than 10 lbs? ____
How many pregnancies? ____ How many children? ____ Date of last menstrual cycle: ____

Males: How many children have you fathered? ____

CURRENT MEDICATIONS: Please list name and dosage: _____

ALLERGIES: Are you allergic to any medications? Please list:

FAMILY HISTORY: Please list **age** and **health issues**, if any. If deceased, please state age at death and cause.

Father _____ **Siblings:** _____
Mother _____

Has any blood relative ever had: Diabetes _____ Thyroid condition _____ Any cancer _____
Heart trouble _____ High cholesterol _____ High blood pressure _____
Any other condition? Please list: _____

SOCIAL HISTORY: Do you use alcohol? How frequently? _____
Do you use tobacco? How frequently? _____
Do you use illicit drugs? Please list: _____
Occupation and highest level of education completed: _____

NAME _____ DATE _____ hhc 7-10

REVIEW OF SYSTEMS:

GENERAL

Any **recent** weight changes? No Yes _____
Have you **recently** felt more tired / loss of energy? No Yes _____
Have you been in poor health most of your life? No Yes _____

SKIN

Any **recent** skin infections or excessive dryness? No Yes _____
Any **new** hair growth / **change** in hair growth? No Yes _____
Any excessive sweating? No Yes _____

HEENT

Headaches? No Yes _____
Difficulty swallowing? No Yes _____
Any change in appearance of face? No Yes _____
Dry mouth? Excessively thirsty? No Yes _____

NECK

Any lumps, swelling, or enlarging of neck? No Yes _____
Any enlarged glands? No Yes _____

ENDOCRINE

Any known thyroid problem? No Yes _____
Any recent hormone therapy? No Yes _____
Are you bothered by cold or warm temperature? No Yes _____

RESPIRATORY

Any difficulty breathing? No Yes _____

CARDIOVASCULAR

Any palpitations? No Yes _____
Any recent onset of chest pain? No Yes _____
Swelling of hands, feet, or ankles? No Yes _____

GASTROINTESTINAL

Frequent diarrhea or constipation? No Yes _____
Cramping or abdominal pain? No Yes _____
Recent change in bowel habits? No Yes _____

GENITOURINARY

Frequent urination? No Yes _____
Kidney stones? No Yes _____
Recent change in menstrual cycles? No Yes _____

MUSCULOSKELETAL

Any weakness of muscles or joints? No Yes _____
Difficulty walking? No Yes _____
Any change in glove/ring size recently? No Yes _____

NEURO-PSYCHIATRIC

Feeling anxious or depressed? No Yes _____
Have you had a seizure recently? No Yes _____

HEMATOLOGIC

Are you slow to heal after cuts? No Yes _____
Any history of anemia? No Yes _____

NAME _____

DATE _____