HEALTH QUESTIONNAIRE

DATE ____

NAME____________________________________ DOB_____________

FAMILY MEDICAL HISTORY

Please list Maternal or Paternal

Alcohol / Drug Abuse:	☐ Yes	☐ No	____________________
Anemia:	☐ Yes	☐ No	____________________
Arthritis:	☐ Yes	☐ No	____________________
Asthma:	☐ Yes	☐ No	____________________
Cancer:	☐ Yes	☐ No	____________________
Depression:	☐ Yes	☐ No	____________________
Diabetes:	☐ Yes	☐ No	____________________
Heart Attack:	☐ Yes	☐ No	____________________
High Blood Pressure:	☐ Yes	☐ No	____________________
High Cholesterol:	☐ Yes	☐ No	____________________
Kidney Problems	☐ Yes	☐ No	____________________
Liver Problems:	☐ Yes	☐ No	____________________
Mental Illness:	☐ Yes	☐ No	____________________
Stroke:	☐ Yes	☐ No	____________________
Thyroid Disease:	☐ Yes	☐ No	____________________

HISTORY OF PAST ILLNESSES

Have you had any of the following?

Childhood (Check all that apply) ☐ **Measles** ☐ **Chicken Pox** ☐ **Rheumatic Fever**

Adult (Check all that apply)

☐ **Anemia**	☐ **Arthritis**	☐ **Asthma**
☐ **High Blood Pressure**	☐ **High Cholesterol**	☐ **Abnormal Heart Rhythm**
☐ **Heart Failure**	☐ **Heart Attack**	☐ **Liver Problems**
☐ **Kidney Problems**	☐ **Alcohol/Drug Abuse**	☐ **Diabetes**
☐ **Stroke/ TIA**	☐ **Cancer**	☐ **Thyroid Problems**

Have you ever been hospitalized? __________________ **When/What For?** __________________________________

Have you ever had surgery?_______________________ **When/What For?** __________________________________

LIFESTYLE & SOCIAL HISTORY

☐ **Weight Loss** ☐ **Weight Gain** ☐ **Seat Belts** ☐ **Bike Helmets**

☐ **Alcohol Use** (# of Drinks per week) _______________ ☐ **Recreational Drug Use** ☐ **Special Diet**

☐ **Tobacco Use** (How long?) _______________ ☐ **Exercise** (Frequency) ____________________

☐ **If Cigarettes, how much per day?** _______________ ☐ **<1 Pack** ☐ **1-2 Packs** ☐ **> 2 Packs**