HEALTHCARE QUESTIONAIRE

DATE: _____

NAME: _____ ADDRESS: _____

What is your present problem? _____

_____

How or when did this start? _____

DIRECTIONS: Circle the correct answer.

Have you ever had:	Mumps	yes	no	Hives	yes	no
	Rheumatic Fever	yes	no	Scarlet Fever	yes	no
	Measles	yes	no	Any blood transfusions	yes	no
	Any allergies	yes	no	Any broken bones	yes	no
	Chicken Pox	yes	no	Any surgery or hospitalization	yes	no

If YES to surgery or hospitalization, fill in the following:

When What Where

_____

_____

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

Asthma	yes	no	Chronic bronchitis	yes	no
Emphysema	yes	no	Tuberculosis	yes	no
Thyroid swelling	yes	no	Over-active Thyroid	yes	no
Under-active Thyroid	yes	no	Heart attack	yes	no
Heart murmur	yes	no	High Blood pressure	yes	no
Enlarged Heart	yes	no	Kidney or bladder disease	yes	no
Severe anemia	yes	no	Kidney or bladder stone	yes	no
Diabetes	yes	no	Gout	yes	no
Stroke	yes	no	Tumor or cancer	yes	no

GENERAL HEALTH:

Are you now in good health? yes no

Have you lost weight, for no apparent reason, over the past six months? Yes no

Have you gained weight, for no apparent reason, over the past six months? Yes no

Do you smoke? Yes no

If yes, check which of the following you smoke:

CIGARETTES	**CIGARS**	**PIPE**
_____ Less than 1 pack a day	_____ 1-5 a day	_____ 1-5 pipefuls a day
_____ 1-2 packs a day	_____ 5-10 a day	_____ 5-10 pipefuls a day
_____ more than 2 packs a day	_____ more than 10 a day	_____ more than 10 a day

Are you taking any thyroid medication at the present time	yes	no
Are you taking any digitalis or other medicine for your heart	yes	no
Are you taking any medicine for high blood pressure	yes	no
Have you ever taken any insulin or other medicine for diabetes	yes	no
Are you taking any reducing medicine to try to lose weight	yes	no
Are you taking any other medicine	yes	no
Are you allergic to any medicine	yes	no

Please list ages and general health of family members or ages and cause of death of deceased:

	Age	Living Health	Age	Deceased (Cause of Death)
Father				
Mother				
Brothers				
Sisters				

NAME: _____ DATE: _____

Do you have frequent, severe headaches yes no
Is your walking weak and unsteady yes no
Are you often dizzy and wobbly yes no
Do you have spells of unconsciousness (complete blackout) yes no
Is your eyesight blurred even when you wear glasses yes no
Do you suffer from eyestrain yes no
Is your eyesight rapidly getting worse yes no
Do you have times when you see double yes no
Do you have sudden short spells of blindness yes no
Are you hard of hearing yes no
Do you hear constant noises in your ears yes no
Do you have any drainage from your ears yes no
Do you have difficulty swallowing yes no
Do you suffer from many heavy chest colds yes no
Are you troubled with frequent coughing yes no
Do you cough up a lot of thick greenish sputum yes no
Do you sometimes cough up blood yes no
Do you ever have severe shortness of breath with your usual daily activity yes no
Do you sleep propped up high in bed to keep from getting short breath yes no
Do you have spells of weakness or paralysis of any part of your body yes no
Have you ever been told you have syphilis or "bad" blood or a positive serology yes no
Are you bothered by weakness or pain in one or both legs while walking yes no
Are both your ankles often swollen yes no
Do you ever have severe pain or pressure or a tight feeling in your chest yes no
Are you bothered by a sudden racing or fluttering of your heart yes no
Have you ever been told by a doctor that you had any abnormal EKG or heart tracing yes no
Do you ever vomit blood yes no
Do any particular foods make you sick yes no
Are you troubled with gas yes no
Have you ever been jaundiced yes no
Do you frequently have diarrhea yes no
Are you often constipated yes no
Do you have any abdominal pain yes no
Do you ever have bloody, tarry bowel movements yes no
Do you usually have to get up from sleep to urinate (pass water) yes no
During the day, do you have to urinate frequently yes no
Do you ever pass bloody or coffee-colored urine yes no
Do you have any pain on urination yes no
Do you have any difficulty starting or stopping your urine yes no
Do you lose any urine when you laugh, cough, or sneeze yes no

FOR WOMEN ONLY

Age at start of menstruation _____
Number of days from the start of your period to the start of the next one _____
Number of days you usually flow _____
Have you ever been pregnant _____
Number of pregnancies_____ Number of living children _____
The first day of your last menstrual period _____
Have you had a "PAP" test _____ When _____ Results _____
If you have passed menopause (change of life), have you had any vaginal bleeding? _____
Do you have bleeding when it is not your menstrual period? _____
Have you noticed any lumps in your breasts? _____

HISTOY OF PREGNANCIES

YEAR	LENGTH OF LABOR	COMPLICATIONS	BIRTH WEIGHT	SEX