HEALTH QUESTIONNAIRE

Please complete this questionnaire so that we can serve your health needs. NOTE: This is confidential information that will not be released to any person except when you have authorized us to do so. Please use back side if you need more space.

Name: **Age:** **Date of Birth:**

Single Divorced
Married Widowed

Date of last physical examination:

Occupation:

Ethnicity: (please circle/check)
Spanish/Hispanic
Non Spanish/Hispanic

Today's date:

Primary Language: **Race:**

Vision or Hearing impaired?

Email address:

Past Surgeries/Hospitalizations
(give details-dates and reasons):

____
____
____
____
____
____
____

List all **medications**, dose and frequency presently being taken (including birth control pills and vitamins):

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____

Is your mother alive? If not, what age did she pass and from what?
____

Is your father alive? If not, what age did he pass and from what?
____

Health problems of any of your siblings?

____
____
____
____

What **specialty doctors** do you see and for what problem?
____
____
____

Transportation issues: Y or N : ______________________

Cultural or health beliefs: Y or N:______________________

Financial concerns : Y or N:______________________

Other concerns or issues: ______________________

Emergency contact name and #
____
____

Date of last Tetanus shot:
____

Allergies (check all that apply):

___ Latex ___ Dyes/Iodine
___ Penicillin ___ Bees/Wasps
___ Sulfa ___ Tetanus
___ Codeine/Morphine
___ Mycin ___ Aspirin
___ Foods
___ Other: ________________

Past Medical History (Check all that apply)

Illnesses:

____ Aids/HIV Disease
____ Allergies, Hay fever
____ Anemia or any bleeding disorders

____ Bone or joint disease
____ Arthritis or Rheumatism
____ Broken bones, Dislocations
____ Bursitis, Sciatica or Lumbago
____ Sprains/strains
____ Gout
____ Polio

____ Asthma
____ Tuberculosis
____ Pleurisy
____ Pneumonia
____ Bronchitis
____ Emphysema

____ Colitis or other bowel disease
____ Gallbladder disease
____ Hepatitis or jaundice
____ Hemorrhoids or any rectal disease

____ Concussion
____ Epilepsy/Seizures
____ Migraine Headaches
____ Meningitis

____ Bladder disease or any urinary Tract disease
____ Gonorrhea, Syphilis, Chlamydia, Herpes or other sexually transmitted disease
____ Kidney disease

____ Heart Disease
____ High or low blood pressure
____ Rheumatic Fever or Heart disease

____ Lacerations
____ Hives or Eczema
____ Frequent infections or boils

____ Measles, German Measles, Mumps
____ Small Pox
____ Chicken Pox

____ Influenza (flu)
____ Cancer
____ Diabetes
____ Glaucoma/Cataracts
____ Food, Chemical, or drug poisoning
____ Other diseases ____

Comments:

Social History

(Check appropriate answer)

Have you ever smoked?

__ Yes __ No

How many packs per day?

____

For how many years?

____

Do you drink alcohol?

__ Yes __ No

If so how much per day/week?

____

Have you ever taken any recreational drugs? (i.e. “pot”, cocaine, crack, etc)

__ Yes __ No

Are you sexually active?

__ Yes __ No

Type of birth control used?

____

Have you ever been abused?

__ Yes __ No

If yes, when?__________________

For Women Only:

Age when your periods started?

____

How many pregnancies?___

Miscarriages:___

Abortions:___________

Date of your last period?

____

Date of your last pap smear?

____

Date of last mammogram?

____

Who is your Gynecologist?

____

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