

Health Survey

Pt. Name: _____

Allergies: _____

List all Medications:

Name	Dose/Strength	How often is it taken?	How long have you been on it?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all previous surgeries: (include your age at the time of surgery or date)

Family History: (List major illnesses, diseases and age/cause of death)

Father: _____

Mother: _____

Siblings (include half-siblings): How many brothers? _____ How many sisters? _____

Brother: _____

Sister: _____

Maternal side of family: _____

Paternal side of family: _____

Social History:

Alcohol: _____ drinks per _____.

Tobacco use: (circle one) cigar cigarette chew pipe _____ per day.

Recreational drugs: (circle one) yes no former use Sexually active: (circle one) Yes No

Cups of coffee per day: _____ soda per day: _____ Tea per day: _____

Rate your diet: Terrible 1 2 3 4 5 6 7 8 9 10 Excellent

Rate your exercise: Terrible 1 2 3 4 5 6 7 8 9 10 Excellent

Symptom Questionnaire

Circle all that apply now or are chronic conditions

Skin

Hives
Fungus of nails
Eczema

Bruising
Acne
Other: _____

Head

Headaches
Dizziness
History of trauma

Migraines
Hair loss
Other: _____

Eyes

Dry eyes
Double vision
Blurred vision
Glaucoma
Other: _____

Watery eyes
Itchy eyes
Discharge
Cataracts

Last Eye Exam: _____

Ears

Frequent ear aches
Drainage
Hearing loss
Other: _____

Fullness in ears
Popping
Frequent infections

Last Hearing Exam: _____

Nose

Runny nose
Nosebleeds
Deviated septum
Other: _____

Chronic sinusitis
Postnasal drip

Mouth

Frequent sore throats
Hoarseness
Voice Change
Other: _____

Difficulty swallowing
Canker sores

Respiratory

Difficulty Breathing
Shortness of breath with exertion
Shortness of breath with lying down (horizontal)
Shortness of breath climbing Mount Everest
Frequent Cough
History of pneumonia
Other: _____

Asthma
History of TB

Cardiovascular

Palpitations
High Blood Pressure
History of Hyperlipidemia (high cholesterol)
Last EKG: _____
Any major Heart History (surgeries etc.):

Chest pain

Heart murmur

Gastrointestinal

Decrease appetite
Constipation
Hemorrhoids
Nausea/Vomiting
Other: _____

Abdominal Pain
Diarrhea
Blood in stool

Unexplained weight change

Family History of:

Gallbladder Colon Stomach Esophageal

Genitourinary

Painful urination
Discharge
Blood in urine
History of kidney stones
Concern for STD
Other: _____

Bad urine odor
Frequent urination
Incontinence
Impotence

Musculoskeletal

Joint pain
Muscle weakness
Neck pain
History of herniated disks
Osteoperosis
Tingling
Other: _____

Muscle pain
Frequent back pain
Sciatica
Muscle cramps
Numbness

Psychiatric

Sleep Difficulties
Anxiety
Other: _____

Depression
Weight or Diet troubles

Any other concerns: _____

