Name:___________________________________ **Doctor:**___________________________________
Date:___________________________________ **Date of Birth:**______________________________

GENERAL HEALTH QUESTIONNAIRE

CHIEF COMPLAINT:
List the medical problem(s) which lead you to seek medical help now, and when each problem began:

a)____
b)____
c)____

1. GENERAL HEALTH:

Height:_________ Weight:________ Handedness: L or R

Are you generally healthy?…………………..…________
If not, why?..___________________________________
Do you have a birth defect?…………………..…________
If so, what? ___________________________________
Have you had:
- Cancer, tumor, or leukemia?…………._______
- Rheumatic or scarlet fever?…………..._______
- Other serious illnesses?………………._______
- If so, what?_______________________________

____

===

2. OPERATIONS:

Have you had any operations?………………..._______
If so, list all previous operations___________________
____
____
____

Any surgical complications?…………………..._______
- If so, explain?____________________________

____
____

3. MEDICINES:

Please list all current medications and their doses:
____
____
____
____

Diabetes, pills or insulin shots?…...……………______
High blood pressure, pills or shots?…………..._______
Diuretics, water pills or shots?………………..._______
Heart medicines, including nitroglycerin?…….._______
Blood thinner pills – Coumadin, etc.?..……….._______
Antibiotics?……………………………………._______
Pain pills, including aspirin?…………………..._______
Tranquilizers or sleeping pills?……………….._______

4. ALLERGIES:
(List all drug allergies)

____
____
____

===

5. SYSTEM REVIEW:

SKIN: Have you had…
- skin infections or boils?……………….______
- sores that do not heal?…………………______
- change in skin moles?…………………______

HEAD: Have you had…
- recent severe headaches?……………._______
- blackout or fainting spells?…………..._______
- convulsions or epilepsy?……………..._______

EYE, EAR, NOSE & THROAT: Have you had…
- glaucoma?……………………………._______
- ear infections?……………………….._______
- trouble with balance?………………..._______
- difficulty or pain with swallowing?…_______

BREAST: (Both men and women please answer)
- Do you have a lump or tumor now?…_______
- Have you had a discharge from a nipple______

HEART & LUNGS:
- Does shortness of breath limit activity?…_______
- Do you prop yourself up to sleep?………_______

Have you had…
- frequent cough?………………………._______
- emphysema?……………………………._______
- chest pain or discomfort?………………._______
- leg cramps at night?…………………….._______
- leg aches when walking?……………….._______
- tuberculosis?…………………………….._______

pneumonia?……………………………..______
coughing up blood?……………………..______

********CONTINUED ON PAGE TWO********

a heart attack or coronary problems?….______
angina?………..…………………..……______
blood clots?……………………………______
an abnormal electrocardiogram?……….______
heart murmur?…………………………______
high blood pressure?..……………..……______
varicose veins or legs?…………………______
swollen ankles?…………………………______
inflamed veins?…………………………______

STOMACH & BOWELS: Have you had…

pain, indigestion or heartburn?……..…______
cramps in the stomach or abdomen?…...______
bloody or black bowel movements?……______
are you taking iron?……………………______
frequent loose stool or diarrhea?………..______
recent change in bowel habits?…………______
stomach, duodenal or peptic ulcer?……..______
hepatitis or cirrhosis?..…………………______
gall bladder disease or pancreatitis?……______

KIDNEY & BLADDER:

do you often get up to urinate?…………______
has urination been painful recently?...…______
do you lose control of your bladder?…..______

GLANDS: Have you had…

sugar diabetes?…………………………______
sugar in urine or blood?…..……………______
a thyroid disorder?……………………..______
other glandular problems?………………______

BLOOD: Have you had…

swollen glands in armpits, neck or groin?.______
excessive bleeding with operations?……______
a diagnosis of "bleeder"?………………______
a diagnosis of anemia, past or present?…______

NERVOUS SYSTEM: Have you…

ever had numbness of your arms or legs?….______
ever lost control of your legs?……………..______
ever lost control of your hands?……………______
ever had a stroke or paralysis?……………..______
often been depressed or worried?…………______
constantly felt tense or nervous?…………..______
been treated for emotional problems?……..______

MUSCLES & BONES: Have you had…

recent severe back pain?……………………______
arthritis or gout?……………………………______
a bone infection (osteomyelitis)?…………..______
recent joint swelling or pain?………………______
a broken bone?……………………………..______

6. FAMILY HISTORY:

Have any of your blood relatives, including children had…

sugar diabetes?…………………………______
cancer, leukemia or Hodgkin's disease?..______
heart trouble?…..………………………______
high blood pressure?……………………______
a stroke?……………………………….._____
anemia or bleeding tendency?…………______
kidney trouble or Bright's disease?…….______
any disease that runs in the family?……______

=====================================

7. PERSONAL & SOCIAL HISTORY:

Are you……married single widowed divorced?
Have any of your children had birth defects?…..______
Do you get regular exercise?……………………______
What is your occupation?…______________________
Are you currently employed?…………………..______
If not, when did you last work?..__________________
Are you disabled?………………………………______
List any hobbies that require special physical skills.
____
____
____
____
Are you retired?………………………………._______
Do you drink alcohol regularly?………………_______
Do you have more than five drinks a day?……..______
Are you currently a smoker?……………………______
How much do you smoke a day?………………______
Have you smoked within the last six months?….______

=====================================

DO YOU HAVE ANY OTHER PROBLEMS THAT HAVE NOT BEEN MENTIONED?………………………..______
If so, please specify:______________________________
____
____
____
____
____

=====================================

Please list all current treating physicians:___________
____
____
____
____
____

=====================================

FOR OFFICE USE ONLY

X-RAY REQUESTED: ___________________________
____

____
PHYSICIAN SIGNATURE