

**HEALTH QUESTIONNAIRE**  
PLEASE ANSWER ALL QUESTIONS AS ACCURATELY AS POSSIBLE

NAME \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_ HT \_\_\_\_ WT \_\_\_\_ WT 1 YR AGO \_\_\_\_\_  
 ARE YOU UNDER A DR'S CARE? \_\_\_\_\_ IF SO, FOR WHAT CONDITION? \_\_\_\_\_  
 NAME AND LOCATION OF YOUR DOCTOR \_\_\_\_\_  
 DATE OF LAST PHYSICAL EXAM \_\_\_\_\_ DATE OF LAST EKG \_\_\_\_\_  
 LIST ANY OPERATIONS OR SERIOUS ILLNESSES \_\_\_\_\_ DATE \_\_\_\_\_  
 \_\_\_\_\_ DATE \_\_\_\_\_  
 \_\_\_\_\_ DATE \_\_\_\_\_  
 \_\_\_\_\_ DATE \_\_\_\_\_

DAILY CONSUMPTION OF: TOBACCO \_\_\_\_\_ ALCOHOL \_\_\_\_\_  
 HAVE YOU HAD A HISTORY OF THE FOLLOWING? ARE YOU TAKING ANY OF THE FOLLOWING? (CIRCLE)

Heart disease, heart attack, stroke, high or low blood pressure, angina, chest pain-----Yes No  
 Shortness of breath-----Yes No  
 Asthma-----Yes No  
 Hives, rashes or skin ailment-----Yes No  
 Seizure disorders-----Yes No  
 Diabetes-----Yes No  
 Hepatitis, jaundice or cirrhosis-----Yes No  
 Ulcer or gastritis-----Yes No  
 Arthritis or rheumatism-----Yes No  
 Kidney disorders-----Yes No  
 Tuberculosis-----Yes No  
 Persistent cough-----Yes No  
 Venereal disease-----Yes No  
 Emotional ailments-----Yes No  
 Abnormal bleeding or anemia-----Yes No  
 Please give dates of any "Yes" answers above:  
 \_\_\_\_\_  
 \_\_\_\_\_

Antibiotics-----Yes No  
 Blood thinners-----Yes No  
 Diet pills or diuretics-----Yes No  
 Medicine for high blood pressure-----Yes No  
 Cortisone (steroids)-----Yes No  
 Aspirin-----Yes No  
 Thyroid medication-----Yes No  
 Tranquilizers-----Yes No  
 Heart medicine (Nitroglycerine, Digoxin, Lanoxin, Inderal, etc)-----Yes No  
 Insulin, Orinase or similar-----Yes No  
 Premarin or other estrogen-----Yes No  
 Other medication (specify)-----Yes No  
 Please identify and give dosages of any of the above:  
 \_\_\_\_\_  
 \_\_\_\_\_

For women: Are you pregnant-----Yes No  
 Breast feeding-----Yes No  
 Take birth control pills-----Yes No

Are you allergic or sensitive to any of the following?  
 General or local anesthetic-----Yes No  
 Penicillin or other antibiotics-----Yes No  
 Sedatives or barbiturates-----Yes No  
 Iodine compounds-----Yes No  
 Adhesive tape-----Yes No  
 Morphine, Codeine or Demerol-----Yes No  
 Aspirin-----Yes No  
 Eggs or shellfish-----Yes No  
 Other \_\_\_\_\_

Do you exercise?-----Yes No  
 How often?-----Yes No  
 Are there any aspects of your physical appearance that bother you?  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you happy with your level of physical fitness? \_\_\_\_\_  
 Are you satisfied with your dietary management? \_\_\_\_\_  
 Are you satisfied with your facial or dental appearance? \_\_\_\_\_

Family history	Age	State of Health	If deceased, age at death	Cause of death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
Children	_____	_____	_____	_____

Signature of patient, parent or guardian \_\_\_\_\_

