

DR. Smith's HEALTH QUESTIONNAIRE

Date: _____

Name: _____ Date of Birth: _____ Age: _____ Sex: M F

Height: _____ Weight: _____ Reason for today's visit: _____

Please list or provide a list of all surgeries or hospitalizations (please include dates): _____

Please list or provide a list of ALL current medications and dosages-including over the counter medications, vitamins, and herbal medications: _____

ALLERGIES to medications: _____

Have YOU or any of your RELATIVES (please list which relative) had any of the following?

Stroke: Y N _____ Heart Attack: Y N _____ High Blood Pressure: Y N _____

Cancer: Y N _____ Diabetes: Y N _____ Hernias: Y N _____ Gallstones: Y N _____

Occupation: _____ Marital Status: S M Sep D W # of Children _____

Tobacco: CURRENT USER (Type-cigarettes, cigars, chew, pipe: _____ Amount per day or week: _____ # of years: _____)
NEVER FORMER (date quit-_____ amount used per day or week-_____)Alcohol: CURRENT USER (Amount: _____ Type beer, wine, liquor - _____ # of years-_____)
NEVER FORMER (date quit-_____)

Are you on a special Diet? Y N Type: _____

Are you now having, or currently being treated for any of the following medical conditions?

ConstitutionalFever Y N
Chills Y N
Weight loss Y N
Malaise/Fatigue Y N
Excessive Sweating Y N
Weakness Y N**Eyes**Blurred vision Y N
Double vision Y N**GI**Heartburn Y N
Nausea Y N
Vomiting Y N
Abdominal Pain Y N
Diarrhea Y N
Constipation Y N
Blood in stool Y N
Black stool Y N**Endocrine/hematology**Easily bruise or bleed Y N
Environmental allergies Y N
Excessive Thirst Y N**Skin**Rash Y N
Itching Y N**Cardiovascular**Chest pain Y N
Irregular heartbeat Y N
Leg swelling Y N**Urology**Burning Y N
Urgency Y N
Frequency Y N
Blood in urine Y N
Flank pain Y N**Neurological**Dizziness Y N
Tingling Y N
Tremor Y N
Seizures Y N**HENT**Headaches Y N
Hearing loss Y N
Ringing in the ears Y N
Nosebleeds Y N
Sore throat Y N**Respiratory**Cough Y N
Shortness (breath) Y N
Wheezing Y N**Musculoskeletal**Muscle aches Y N
Back pain Y N
Joint pain Y N**Psychiatric**Depression Y N
Suicidal ideas Y N
Substance abuse Y N
Nervous/Anxious Y N
Memory Loss Y N