

Clinical Health Questionnaire

Please complete this form as accurately as possible:

Name: _____

DOB: _____ Age: _____ Gender: M F

Physicians currently treating you:

Reason for visit: _____

Have you had a flu shot: Yes No Date of shot: _____

Past Medical History (current or past illnesses)

Heart

High Blood Pressure Yes No

High Cholesterol Yes No

Coronary Artery Disease Yes No

Irregular Heart Beat Yes No

Heart attack Yes No

Other: _____

Lung

COPD Yes No

Emphysema/Chronic Bronchitis Yes No

Asthma Yes No

Pneumonia Yes No

Other: _____

Gastrointestinal

Reflux Disease (Hiatal Hernia) Yes No

Peptic Ulcer Disease Yes No

Gall Bladder Disease Yes No

Hepatitis B or C Yes No

Inflammatory Bowel disease (Crohn's, Ulcerative Colitis) Yes No

Liver Cirrhosis Yes No

Other: _____

Endocrine

Diabetes Yes No

Thyroid Disease Yes No

Other: _____

Cancer

Ever diagnosed with cancer? Yes No

Year diagnosed: _____

Type of Cancer: _____

Are you on Treatment? Yes No

Blood Disorders

Anemia Yes No

Bleeding disorders Yes No

Other: _____

Musculoskeletal System

Osteoarthritis Yes No

Gout Yes No

Autoimmune Disease Yes No

If yes, please explain: _____

Other: _____

Peripheral Vascular Disease

Deep Vein Thrombosis (DVT) Yes No

Pulmonary Embolism (PE) Yes No

Varicose Veins Yes No

Arterial Vascular Disease Yes No

Other: _____

Psychological Disorders

Depression Yes No

Anxiety Yes No

Other: _____

Neurologic Disorders

Stroke Yes No

Alzheimer's Yes No

Other: _____

Pregnancy status: Yes No If yes how many months: _____

Other illnesses not listed above: 1. _____

2. _____ 3. _____

Past Surgical History (please list all prior surgical procedures)

None

Type of surgery: _____ Year: _____

Type of surgery: _____ Year: _____

Type of surgery: _____ Year: _____

Type of surgery: _____ Year: _____

Have you had any complications after surgery? Yes No

If yes, please explain: _____

Family History (Circle M-Mother F-Father S-Sister B-Brother)

Gallstones M F S B

Colon Polyps M F S B

Diabetes M F S B

High Blood Pressure M F S B

Hemochromatosis M F S B

(Iron storage disease)

Ulcers M F S B

Colon Cancer M F S B

Depression M F S B

Arthritis M F S B

Hepatitis M F S B

Liver Cancer M F S B

Heart Disease M F S B

Colitis M F S B

Crohn's disease M F S B

Other Liver Diseases: _____

Other Cancers: _____

Genetic Diseases: _____

Has any family member had any of the following?

Difficulty with Anesthesia: Yes No

Excessive bleeding after a procedure: Yes No

If yes, please explain: _____

Social History

Tobacco use: Current Past None

If yes, average use: ___pack/day Duration: ___years

Quit (if applicable) ___Years ago

Alcohol Use: Current Past None

If yes, average use: ___drinks/week

When was your last drink: _____

Quit (if applicable) ___years ago

Recreational Drug Use: Yes Never Quit

Review of Systems

Please circle any of the following symptoms you might have Experienced over the past 3 months (if this form is left blank we will assume that there have been no issues)

Constitutional: Fever, Chills, Tiredness, Weight loss >10lbs

Psychologic: Anxiety, Depression, Difficulty Sleeping

Neurologic: Dizziness, Hand/Feet tingling or numbness

Eyes: Blurry Vision, Eye Pain

Ear/Nose/Throat: Ear ache, Nose Bleed, Change in Voice

Heart: Chest pain, Shortness of Breath, Heart Palpitations

Lungs: Cough, Sputum, Shortness of Breath, Wheezing

Gastrointestinal: Abdominal pain, Heartburn, Nausea, Vomiting, Bloating, Diarrhea, Constipation, Blood from Rectum

Genitourinary: Burning with Urination, Increased frequency, Difficulty Controlling Bladder, Penile or Vaginal Discharge

Musculoskeletal: Pain in joints, muscles, or bones

Skin: Skin rash, Excessive itching, Eczema, Dry skin

Hematologic: Excessive bruising, swollen glands

Current Medications

Please list all prescribed and over-the-counter medications, Including nutritional and herbal supplements you are currently taking. (Please submit separate list if your list is longer then what this table allows)

Allergies:

Please list all allergies and reactions.

Drug Allergy	Reaction

Prescription Medication	Dose (mg, iu, cc)	Frequency

Name, phone#, address of your pharmacy: _____