

Health Questionnaire

This medical questionnaire will be helpful in developing a care plan for you. Please be as accurate as possible. I appreciate you taking the time filling it out.

Basic Information
Full Legal Name:
Nick Name(s):
Date of Birth:
Address:
Home Phone:
Cell Phone:
Email:
Your pharmacy/phone number:
Insurance Provider
Name/Policy #:
Address:
Previous Primary Care Provider and contact information
Name:Phone/Fax
- · · · · · · · · · · · · · · · · · · ·
List your Specialists and Surgeons



Past Medical History

Medications. Please list all medication prescribed and over the counter, herbs,_ etc Allergies and Intolerances: Past Surgical History. Please list any surgeries or procedures	Please list all diagnoses, i.e Diabetes, high blood pressure, etc.
Allergies and Intolerances:	
	Medications. Please list all medication prescribed and over the counter, herbs,_ etc
Past Surgical History. Please list any surgeries or procedures	Allergies and Intolerances:
Past Surgical History. Please list any surgeries or procedures	
Past Surgical History. Please list any surgeries or procedures	
Past Surgical History. Please list any surgeries or procedures	
Past Surgical History. Please list any surgeries or procedures	
	Past Surgical History. Please list any surgeries or procedures



Social History

average
Did you quit? What is the date you quit?
Alcohol use: How much, how often and type of alcohol?
Drug use: List any illicit drug use. Have you ever done IV drug use?
Occupation(s)/Retired?
Highest Level of Education completed
Hobbies/Interests:
Religion
Family History, please list any medical conditions
Were you adopted? Mother
Father
Siblings/Cousins



Review of Systems

CHECKLIST: Review of Systems Checklist:
General- □ Weight loss or gain □ Fatigue □ Fever or chills □ Weakness □ Trouble sleeping
Skin- □ Rashes □ Lumps □ Itching □ Dryness □ Color changes □ Hair and nail changes
Head- □ Headache □ Head injury
Ears- □ Decreased hearing □ Ringing in ears (tinnitus) □ Earache □ Drainage
Eyes- □ Vision □ Glasses or contacts □ Pain □ Redness □ Blurry or double vision □ Flashing lights □ Specks □ Glaucoma □ Cataracts □ Last eye exam
Nose- □ Stuffiness □ Discharge □ Itching □ Hay fever □ Nosebleeds □ Sinus pain
Throat- Teeth Gums Bleeding Dentures Sore tongue Dry mouth Sore throat Hoarseness Thrush Non-healing sores Last dental exam
Neck- □ Lumps □ Swollen glands □ Pain □ Stiffness
Breasts- □ Lumps □ Pain □ Discharge □ Self-exams □ Breast-feeding

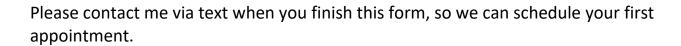


Coughing up blood (hemoptysis) Shortness of breath (dyspnea) Wheezing Painful breathing
Cardiovascular- Chest pain or discomfort Tightness Palpitations Shortness of breath with activity (dyspnea) Difficulty breathing lying down (orthopnea) Swelling (edema) Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)
Gastrointestinal- □ Swallowing difficulties □ Heartburn □ Change in appetite □ Nausea □ Change in bowel habits □ Rectal bleeding □ Constipation □ Diarrhea □Yellow eyes or skin (jaundice)
Urinary- □ Frequency □ Urgency □ Burning or pain □ Blood in urine (hematuria) □ Incontinence □ Change in urinary strength
Genital Male- □ Pain with sex □ Hernia □ Penile discharge □ Sores □ Masses or pain □ Erectile dysfunction □ STD's Female- □ Pain with sex □ Vaginal dryness □ Hot flashes □ Vaginal discharge □ Itching or rash □ STD's
Vascular- □ Calf pain with walking (Claudication) □ Leg cramping
Musculoskeletal- □ Muscle or joint pain □ Stiffness □ Back pain □ Redness of joints □ Swelling of joints □ Trauma



Neurologic- □ Dizziness □ Fainting □ Seizures □ Weakness □ Numbness □ Tingling □ Tremor
Hematologic- □ Ease of bruising □ Ease of bleeding
Endocrine- □ Head or cold intolerance □ Sweating □ Frequent urination (polyuria) □ Thirst (polydypsia) □ Change in appetite (polyphagia)
Psychiatric- □ Nervousness □ Depression □ Memory loss □ Stress
Goals
What are your health and wellness goals?





Thank you and see you soon!

Bob Dalrymple, MD 775-530-6626