HEALTH QUESTIONNAIRE

NAME_____ AGE_____ DATE_____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had:

Childhood:

Measles	yes / no	Strokes	yes / no	Rheumatic fever or heart disease	yes / no
Mumps	yes / no	Cancer	yes / no	Congenital Abnormalities	yes / no
Chickenpox	yes / no	Tuberculosis	yes / no	Other serious diseases	yes / no
Diabetes	yes / no	Venereal disease	yes / no		

Adult:

Have you had any serious illness? yes / no

Have you ever been hospitalized or under medical care for very long? yes / no

If yes, for what reason? _____

Operations:

Have you had any surgery?.....No Yes

List _____

_____

_____

IMMUNIZATION	NO	YES	YEAR
Measles			
Mumps			
Flu			
Tetanus			
Pneumonia			

Injuries:

Have you had any broken bones? ..... No Yes

Have you had any head concussions or injuries? ..... No Yes

Have you ever been knocked unconscious? ..... No Yes

FAMILY HISTORY	If Living: Age	Health	If Deceased: Age (at death)	& Cause	Has any blood relative ever had:		
Father					Cancer	No	Yes
Mother					Tuberculosis	No	Yes
Brother / Sister					Diabetes	No	Yes
					Heart trouble	No	Yes
					High blood pressure	No	Yes
					Stroke	No	Yes
Husband / Wife					Convulsions	No	Yes
Son / Daughter					Suicide	No	Yes
					Mental illness	No	Yes
					Bleeding tendency	No	Yes
					Gout or other arthritis	No	Yes
					Hereditary defects	No	Yes

SOCIAL HISTORY:

Circle one: Single Married Separated Divorced Widowed

Are you living with your husband or wife? .....No Yes

Is your sex life satisfactory? .....No Yes

Do you have dependants at home? .....No Yes

Alcoholic Beverages: Never ____ Rarely ____ Moderately ____ Daily ____ Ever? ____

Tobacco: Cigarettes ____ Packs a day ____ Don't smoke ____ Ever smoked? ____

Are you employed? Full time ____ Part time ____

What is your job? _____

Are you exposed to fumes, dust or solvents? _____

Education: (Years) Grade School ____ High School ____ College ____ Postgraduate ____

How much time have you lost from work because of your health during the past? Six Months ___ One Year ___ Five Years ____

ALLERGIES AND SENSITIVITIES:

1. Is there a history of skin reaction or other untoward reaction to sickness following injection or oral administration of:

Penicillin or other antibiotics	Yes	No	Don't know
Morphine, Codeine, Demerol or other narcotics	Yes	No	Don't know
Novacain or other anesthetics	Yes	No	Don't know
Aspirin, emperin or other pain remedies	Yes	No	Don't know
Sulfa drugs	Yes	No	Don't know
Tetanus antitoxin or other serums	Yes	No	Don't know
Adhesive tape	Yes	No	Don't know
Iodine or Merthiolate	Yes	No	Don't know
Any other drug or medication	Yes	No	Don't know
Any foods, such as egg, milk or chocolate	Yes	No	Don't know

List Drug or food Allergies:

_____

_____

_____

_____

_____

_____

2.Drugs Recently Taken within the past three months:

_____

_____