



HEALTH QUESTIONNAIRE

Today's Date: _____

Name: _____ Date of birth: ____/____/____ Age ____

Reason for visit: _____

Name of primary care physician: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have

- | | | |
|--|---|--|
| <input type="checkbox"/> Recent fevers/sweats | <input type="checkbox"/> Cough/wheeze | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Anxiety/depression |
| <input type="checkbox"/> Change in vision | <input type="checkbox"/> Heartburn/reflux | <input type="checkbox"/> Increased stress |
| <input type="checkbox"/> Difficulty hearing | <input type="checkbox"/> Nausea/vomiting/diarrhea | <input type="checkbox"/> Unexplained lumps |
| <input type="checkbox"/> Hay fever/allergies | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Easy bruising/bleeding |
| <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Painful/bloody urination | <input type="checkbox"/> Heat/cold intolerance |
| <input type="checkbox"/> Chest pain/discomfort | <input type="checkbox"/> Penile/vaginal discharge | <input type="checkbox"/> Increased thirst/appetite |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Muscle/joint pain | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Back pain | |

- SKIN CONDITIONS**
- Eczema
 - Psoriasis
 - Other rashes
 - New/changing moles
 - Melanoma
 - Other skin cancer
 - Frequent sun exposure
 - Scarring/keloids
 - Hives

MEDICAL HISTORY: Check if you have any of the following

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Asthma/hay fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer (What type?) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Colitis (UC, Crohn's, IBS) | <input type="checkbox"/> Herpes | <input type="checkbox"/> Alcohol use/Smoking (circle) |
| <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Depression/Anxiety | | <input type="checkbox"/> Sexually transmitted disease |

FAMILY HISTORY: Indicate if family members have any of the following

	MOTHER	FATHER	SISTER/BROTHER
Eczema			
Psoriasis			
Melanoma			
Other skin cancer (SCC, BCC)			
Easy bleeding			

FEMALE PATIENTS:

Pregnant or nursing?	Yes	No
Regular menstrual periods?	Yes	No
Menopausal symptoms?	Yes	No
Birth control pill?	Yes	No
If yes, brand:		

MEDICATIONS: Please list prescription and non-prescription medicines, vitamins, herbs, supplements (*continue on back if needed*)

DO YOU HAVE ALLERGIES TO MEDICINES? YES NO

If yes, please list: _____

*Doctor has reviewed
medical information above
with patient*

PATIENT/GUARDIAN SIGNATURE: _____

DOCTOR SIGNATURE: _____