# HEALTH QUESTIONNAIRE

Formedic

**REASON FOR VISIT**

## FAMILY HISTORY

*IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE*

| | | | |
|---|---|---|---|
| 1) Epilepsy | 6) Thyroid | 11) Osteoporosis | 16) High cholesterol |
| 2) Migraine | 7) Hayfever | 12) Arthritis | 17) Alcoholism |
| 3) Mental illness | 8) Asthma | 13) Heart disease | 18) Hepatitis |
| 4) Glaucoma | 9) Anemia | 14) Stroke | 19) Cancer |
| 5) Diabetes | 10) Bleeds easily | 15) High blood pressure | 20) |

## HOSPITAL ADMISSIONS

*not including pregnancies*

| YEAR | ILLNESS OR OPERATION | YEAR | ILLNESS OR OPERATION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## LIST ALL MEDICATIONS YOU ARE NOW TAKING - INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION

## ALLERGIES

## SUPPLEMENTS

## VACCINE

| | YEAR OF LAST |
|---|---|
| Tetanus / Td | |
| Influenza (flu) | |
| Pneumonia | |
| Hepatitis | |
| | |

## TEST / EXAM

| | YEAR OF LAST |
|---|---|
| Rectal / stool | |
| Cholesterol | |
| Eye exam | |
| TB test | |
| Hepatitis | |

## MEDICAL HISTORY

*MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.*

- ☐ Decreased hearing
- ☐ Ringing in ear
- ☐ Ear infections - *frequent*
- ☐ Dizzy spells ☐ Fainting spells
- ☐ Failing vision ☐ Eye pain
- ☐ Double or blurred vision
- ☐ Nose bleeds - *recurrent*
- ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
- ☐ Shortness of breath:
  - ☐ on exertion ☐ lying flat
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain - *when walking*
- ☐ Varicose veins / Phlebitis
- ☐ Cold numb feet
- ☐ Loss of appetite - *recent*
- ☐ Difficulty swallowing
- ☐ Heartburn ☐ Peptic ulcer
- ☐ Nausea/Vomiting ☐ Abdominal pain
- ☐ Abdominal pain
- ☐ Gallbladder trouble
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Inflammatory Bowel Syndrome
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids ☐ Hernia

Urination - Overactive Bladder

- ☐ Overnight more than twice
- ☐ More than 8 times / 24 hrs.
- ☐ Urgency to urinate ☐ with leakage

- ☐ Decrease in force/flow ☐ Painful
- ☐ Stress incontinence — urine leakage with exercise / movement
- ☐ Blood in urine ☐ Kidney stones
- ☐ Urine infections - *frequent*
- ☐ Bed wetting
- ☐ Weight loss / gain ☐ Height loss
- ☐ Appetite
- ☐ Anemia ☐ Bruise easily
- ☐ Blood transfusions
- ☐ Cancer ☐ Easily fatigued
- ☐ Decreased energy / endurance
- ☐ Diabetes ☐ Thyroid disease
- ☐ Seizures ☐ Stroke
- ☐ Tremor ☐ Memory loss
- ☐ Headaches ☐ Numbness
- ☐ Arthritis / Rheumatism
- ☐ Bone fracture / joint injury
- ☐ Osteoporosis ☐ Back pain
- ☐ Foot pain ☐ Gout
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Depression
- ☐ Decreased life enjoyment
- ☐ Decreased work performance
- ☐ Sleep problems
  for how long ____ how often ____
  sleeping - ☐ too little ☐ too much
  ☐ waking refreshed
- ☐ Concentration problems
- ☐ Thoughts of - death ☐ suicide
- ☐ Anxiety ☐ Mood swings ☐ Phobias
- ☐ Vague aches and pains
- ☐ Mental illness
- ☐ Sexual problems / enjoyment
- ☐ Rheumatic Fever ☐ Scarlet Fever
- ☐ Chickenpox ☐ Polio ☐ Mumps
- ☐ Measles ☐ German measles
- ☐ Tuberculosis ☐ Herpes
- ☐ AIDS / HIV ☐ STD
- ☐ Alcohol _____ oz. per week
- ☐ Coffee / Tea _____ cups per day
- ☐ Smoking - cig/day____ # years
  year quit ____
- ☐ Exercise _____
- ☐ Street drugs _____
- ☐ Unwanted facial hair

Hair loss: ☐ progressive ☐ recent

**MALES -** ☐ Prostate problems

**FEMALES -** *Please complete*

**Menstrual flow:**

☐ Reg. ☐ Irreg. ☐ Pain / Cramps

Days of flow____ Length of cycle____

Date — 1st day of last period ____

☐ Pain / Bleeding during or after sex

Number of:

Pregnancies ____ Abortions ____

Miscarriages ____ Live births ____

Birth control method _____

B.C. pill (name) _____

☐ Flushing / Menopause

Date of last Pap test _____

☐ Normal ☐ Abnormal

Date of last mammogram _____

☐ Normal ☐ Abnormal

## NOTES

LITHO IN CANADA