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HEALTH QUESTIONNAIRE

On behalf of the staff, I would like to welcome you to our office. Please respond to the following questions in as complete and honest a manner as possible. Remember, your health may depend on the information you furnish to your physician.

Name:___________________________________ Date:______________

Please list all health problems which you would like help with today:

Problem:	How long has it been a problem?
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

If there are more problems, please list on back of page.

When was the last time that you felt normal? _____________________

Have you been treated by any physician or health practitioner during the past year for any of the above problems? yes no

If so, what treatment was ordered? ______________________________

____

In what ways, if any, did it help? _______________________________

____

In your opinion, what needs to be done to solve your problems? ___

____

What prescription medications are you taking at present? ____none

Medication and strength:	How long have you taken it?	How often do you take it?
1. ____________	____________	____________
2. ____________	____________	____________
3. ____________	____________	____________
4. ____________	____________	____________
5. ____________	____________	____________
6. ____________	____________	____________

Please list any additional medications on back of page.

What medications, if any, are you allergic to? ___None. ____________

____

Have you been diagnosed with any chronic medical condition?

Diagnosis:	Year:	Currently being treated?	With what?
____High blood pressure	______	Y N	____________
____Other heart problem	______	Y N	____________
____Diabetes	______	Y N	____________
____Arthritis	______	Y N	____________
____Epilepsy	______	Y N	____________
____Schizophrenia	______	Y N	____________
Other (list):			
____________	______	Y N	____________
____________	______	Y N	____________

Please list all operations you have had, starting with the most recent:

Operation:	Date:
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________

If you need additional space, use the back of this page.

Have you had any surgical implants, prosthetic devices, or other foreign substances placed within your body? Yes No. If yes, describe what and when:
____

DENTAL HISTORY: Do you have any "silver" fillings in your teeth? Yes___No___.

How old were you when the first fillings were placed? __________. When was the most recent filling placed? __________. Do you have any root canals? Y__ N__ . How many? _____. Do you have dentures? Yes___ No___. Since when? ___________.

NUTRITIONAL HISTORY:

Do you usually eat:	YES	NO	TYPE OF FOOD:
Breakfast	____	____	________________
Lunch	____	____	________________
Dinner	____	____	________________
Between meals	____	____	________________
Before bed	____	____	________________

HOW OFTEN DO YOU EAT THE FOLLOWING? [Please mark the best answer.]

More than once each:

	Day:	Week:	Month:	Never:
1. Milk	_____	_____	_____	_____
2. Dairy Products	_____	_____	_____	_____
3. Coffee	_____	_____	_____	_____
4. De-Caff coffee	_____	_____	_____	_____
5. Sugar	_____	_____	_____	_____
6. White bread	_____	_____	_____	_____
7. Margarine	_____	_____	_____	_____
8. Nutrasweet	_____	_____	_____	_____
9. Soft drinks	_____	_____	_____	_____
10. Beer,wine,etc	_____	_____	_____	_____
11.Fresh vegetables	_____	_____	_____	_____
12.Frozen vege's	_____	_____	_____	_____
13.Canned vege's	_____	_____	_____	_____
14. Salads	_____	_____	_____	_____
15. Fresh fruit	_____	_____	_____	_____
16. Frozen fruit	_____	_____	_____	_____
17. Beef, lamb	_____	_____	_____	_____
18. Pork,ham,bacon	_____	_____	_____	_____
19. Fish	_____	_____	_____	_____
20. Seafood	_____	_____	_____	_____

21. Poultry ____ ____ ____ ____

22. Pastries ____ ____ ____ ____
23. T.V. Dinners ____ ____ ____ ____
24. Italian Food ____ ____ ____ ____
25. Chinese Food ____ ____ ____ ____
26. Fast Food ____ ____ ____ ____

Do any foods seem to make you feel worse? Yes___ No___. If yes, name them and describe what symptoms are produced.
[Example: Milk → mucus in throat]:

____

____.

Are you at present on any special diet? Yes____ No____. If yes,

please describe: ____

____

Are you currently taking any vitamin or mineral supplements?
Please list:

____

____

Please list any herbal or homeopathic preparations you are taking at present:

____

____

How often do you take the following OTC [over the counter] medications?

	Never	Occas.	#/Day-Week-Month
1. Acetaminophen or Tylenol	____	____	______ per D W M
2. Aspirin: Anacin,Bufferin	____	____	______ per D W M
3. Advil/Alleve or other pain	____	____	______ per D W M
4. Antihistamines/allergy	____	____	______ per D W M
5. Decongestants: Sudafed,etc	____	____	______ per D W M
6. Laxatives/Stool softeners	____	____	______ per D W M
7. Antacids: Mylanta,Maalox	____	____	______ per D W M
8. Other OTC:_______________	____	____	______ per D W M

HABITS:

Have you ever smoked cigarettes? Yes____ No____. Age started ______yrs. How many years of your life have you smoked? ______
How many packs per day do you presently smoke? _____P/D; how much were you smoking 1 year ago? ______P/D. When did you stop smoking?

___________________. Why? ____.
Have you ever smoked cigars? Yes___ NO___
Have you ever smoked a pipe? Yes___ No___
Do you currently chew tobacco? Yes___ No___
How many cans per week? _____. How long have you chewed tobacco? _____ years. Does anyone in your household smoke? Yes____ No____.
If yes, how many individuals? ________________.
How often do you chew gum? Never____ Occasionally____ Frequently____ Nearly constantly____. If frequent or constantly, for how many years? _____ years.
How much water, on the average, do you drink each day? ______ cups/day.
How many cups of coffee do you drink each day? _________. Is that more or less than 1 year ago? More____ Less____. How many glasses of tea per day? _______.
How many (12 oz) cans of Cola (caffeinated) soft drinks per day? ____________.
Do you drink regular or Diet soft drinks? Regular ____ Diet _____.
Do you drink alcohol? Yes ____ No____

Average amount per week:	For how many years?
Beer__________________________	______________
Wine__________________________	______________
Liquor________________________	______________

Have you ever used alcohol to excess? Yes____ No____
Have you ever been treated for alcoholism? Yes____ No____

Have you ever used recreational or pleasure drugs? Yes____ No____

If yes, which?	How much, how often, and for how long?	Current?
_____Marijuana (pot)	____________________________________	Y N
_____Cocaine	____________________________________	Y N
_____Heroin	____________________________________	Y N
_____Amphetamines, Speed	____________________________________	Y N
_____Sedatives, tranquilizers	____________________________________	Y N
_____LSD, mescaline, hallucinogens	____________________________________	Y N
_____I.V. use (mainline)	____________________________________	Y N
_____Other:_____________________	____________________________________	Y N

What time of day do you usually go to bed? ________________
How many hours do you usually sleep? ______ Do you sleep well? Yes___ No___

SOCIAL HISTORY:
Place of birth: ______________________________________ Date of birth __________

How many brothers did you have? _____. How many sisters? _____. What was your position in the family? _______. For how many months were you breastfed? _____.
List all states in which you have lived for more than 1 year:___________________
____
Have you ever been married? Y__ N__ How many times? ______
Current marital status: __Single __Married __Divorced __Widowed __Living together
Education: How many grades have you completed? ___12 (H.S.) ____16 (COLLEGE)
OTHER [List]:______