

Health Survey

Patient's Name: _____

Allergies (medicines): _____

List all Medications:

Name	Dose/Strength	How often is it taken?	How long have you been on it?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all previous surgeries: (include your age at the time of surgery or date)

List all medically diagnosed diseases and/or illnesses: (include date/year of diagnosis)

Family History: (List major illnesses and diseases – For example: Heart attack, stroke, high blood pressure, high cholesterol, diabetes, autoimmune illnesses, etc.)

Father: (Alive/Deceased) _____

Mother: (Alive/Deceased) _____

Brother: (Alive/Deceased) _____

Sister: (Alive/Deceased) _____

Maternal side of family:

Grandmother (Alive/Deceased) _____ Grandfather (Alive/Deceased) _____

Paternal side of family:

Grandmother (Alive/Deceased) _____ Grandfather (Alive/Deceased) _____

Social History:

Alcohol Type: (circle one) Wine Beer Hard Liquor per: Day _____ Week _____ Month _____

Tobacco Use: (circle one) Cigar Cigarette Chew Pipe _____ per day.

Never Smoked Former Smoker

Recreational Drugs: (circle one) Medical Marijuana | Marijuana | Former Use | Other _____

Symptom Questionnaire

Circle all that apply now or are chronic conditions

Skin

Hives
Fungus of nails
Eczema

Bruising
Acne
Other: _____

Head

Headaches
Dizziness
History of trauma

Migraines
Hair loss
Other: _____

Eyes

Dry eyes
Double vision
Blurred vision
Glaucoma

Watery eyes
Itchy eyes
Discharge
Cataracts

Other: _____

Ears

Frequent ear ache
Drainage
Hearing loss
Other: _____

Fullness in ears
Popping
Frequent infections

Nose

Chronic sinusitis
Postnasal drip
Other: _____

Nosebleeds
Deviated septum

Mouth

Frequent sore throats
Hoarseness
Voice Change
Other: _____

Difficulty swallowing
Canker sores

Respiratory

Difficulty Breathing
Shortness of breath with exertion
Shortness of breath with lying down (horizontal)
Shortness of breath climbing Mount Everest ☺
Frequent Cough
History of pneumonia
Other: _____

Asthma
History of TB

Cardiovascular

Palpitations
High Blood Pressure
History of Hyperlipidemia (high cholesterol)
Last EKG: _____
Any major Heart History (surgeries etc.):

Chest pain

Heart murmur

Gastrointestinal

Decreased appetite

Abdominal Pain

Constipation

Diarrhea

Hemorrhoids

Blood in stool

Nausea/Vomiting

Other: _____

Unexplained weight change

Family History of:

Gallbladder Colon Stomach Esophageal

Genitourinary

Painful urination

Bad urine odor

Discharge

Frequent urination

Blood in urine

Incontinence

History of kidney stones

Impotence

Concern for STD

Other: _____

Musculoskeletal

Joint pain

Muscle pain

Muscle weakness

Frequent back pain

Neck pain

Sciatica

History of herniated disks

Muscle cramps

Osteoporosis

Numbness

Tingling

Other: _____

Psychiatric

Sleep Difficulties

Depression

Anxiety

Weight or Diet troubles

Other: _____

Any other concerns: _____

