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)

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____ ____

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Family History: (List major illnesses and diseases – For example: Heart atta k, 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
Bruising
Fungus of nails
Acne
Eczema
Other:__________

Head

Headaches
Migraines
Dizziness
Hair loss
History of trauma
Other:_________

Eyes

Dry eyes
Watery eyes
Double vision
Itchy eyes
Blurred vision
Discharge
Glaucoma
Cataracts
Other:______________________________

Ears

Frequent ear ache
Fullness in ears
Drainage
Popping
Hearing loss
Frequent infections
Other:________________________________

Nose

Chronic sinusitis
Nosebleeds
Postnasal drip
Deviated septum
Other:_______________________________

Mouth

Frequent sore throats
Difficulty swallowing
Hoarseness
Canker sores
Voice Change
Other:___________________________________

Respiratory

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

Cardiovascular

Palpitations
Chest pain
High Blood Pressure
Heart murmur
History of Hyperlipidemia (high cholesterol)
Last EKG: ____________________
Any major Heart History (surgeries etc.):
____
____
____

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: ________________________

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