FAMILY MEDICINE OF PORT ANGELES

HEALTH QUESTIONNAIRE

DATE: ____________ **GENDER:** _______ **M** _______ **F** **AGE:** _____________

NAME (PLEASE PRINT): ____

Do you go to any doctors other than your doctor at Family Medicine? ______ NO ______ YES
If yes, names: ____

HEALTH HISTORY: CIRCLE AND/OR FILL IN APPROPRIATE BLANKS

Major Illnesses: None, Diabetes, High Blood Pressure, Heart Trouble, Cancer, Arthritis
Other ____
____

Major Surgeries: None, Tonsils, Appendix, Hernia, Gallbladder, Hysterectomy,
Other ____
____

Major Injuries: None, Broken Bones, Head Injuries, Etc: ______________________________
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Pregnancies: _______ NO ______ YES Number and dates of delivery: ______________________

Vaginal or Cesarean Section: ______________________________
Miscarriages(s) and Date(s): ______________________________

Social: Marital Status: ______________________ Name of Spouse/Partner: ______________________
Children: How many and ages? ______________________________
Tobacco: None; Cigarettes _______ per day; Cigars _______ per day; Pipe? _____ Chew? _____
Alcohol: None; ________ Drinks per day/ week/ month Coffee/Tea/Soda ________ cups per day
Occupation: ___________________ Hobbies/Interests ______________________________
Where were you born? ______________________ When did you move to Port Angeles? _____________
Name and phone number of nearest relative: ______________________________
Do you have a living will? ______________________________

Immunizations: (Date of last booster)
Tetanus ______________ Flu ______________ Pneumonia ____________ Hepatitis B ____________

Annual Care: Please write approximate date you last had the following done (if known):
Pap Smear ________ Mammogram ________ Colonoscopy _______ Physical _________ Cholesterol _________

MEDICATION HISTORY: List medications you take every day (ie. Vitamins, Aspirin, Laxatives, Digitalis, Birth Control Pills, Thyroid, etc.: ______________________________
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____
____

List any DRUG Allergies (Penicillin, Tetracycline, Sulfa, Codeine, Aspirin, Etc.):
____

List any OTHER Allergies (hay fever, dust, etc.) you might have:
____

FAMILY HISTORY: Does anyone or did anyone have any of the following diseases? If so, who?

Heart Disease: ______________________ High Blood Pressure: ______________________
High Cholesterol: ______________________ Diabetes: ______________________
Stroke: ______________________ Breast Cancer: ______________________
Colon Cancer: ______________________ Ovarian Cancer: ______________________
Uterine/Cervical Cancer: ______________________ Prostate Cancer: ______________________
Mental Illness: ______________________ Other major diseases: ______________________

DIRECTIONS: Circle either the "YES" or "NO" for each question. If you are not sure, guess.

DO YOU NOW HAVE OR DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

Constitutional

1) Unexplained weight gain or loss? YES NO
2) Constant fatigue, exhaustion, weakness? YES NO
3) Fever, chills, night sweats (soaking)? YES NO

Eyes

4) Wear glasses or contacts? YES NO
5) Any other eye trouble, such as blurred vision, double vision, eye pain, dry or red eyes, watery or itchy eyes? YES NO

ENT & Neck

6) Poor hearing or constant ringing in your ears? YES NO
7) Constant or recurrent ear, mouth or throat pain? YES NO
8) Neck pain or stiffness? YES NO
9) Hay fever or constant runny, itchy or stuffy nose, sneezing? YES NO
10) Frequent bloody nose or bleeding gums? YES NO

Cardiovascular

11) Pain or pressure in your chest with exercise or excitement? YES NO
12) Frequent periods of heart racing, pounding or beating irregularly? YES NO
13) Awakening in the night completely out of breath? YES NO
14) Frequent swelling in your ankles? YES NO
15) Frequently cold hands or feet? YES NO
16) Constant pain in your calves when exercising that resolves with rest? YES NO

Respiratory

17) Unexplained shortness of breath? YES NO
18) Persistent cough or wheezing? YES NO
19) Asthma or emphysema? YES NO
20) Coughing up blood? YES NO

Gastrointestinal

21) Severe stomach pains? YES NO
22) Indigestion, heartburn, frequent vomiting? YES NO
23) Excessive belching or bloating? YES NO
24) Diarrhea (more than 3 soft stools daily) or constipation? YES NO
25) Frequent nausea or vomiting? YES NO
26) Trouble swallowing? YES NO
27) Recent change in your bowel movements? YES NO
28) Vomited blood or blood in stools? YES NO
29) Hepatitis or yellow jaundice? YES NO
30) Bowel movements as black stool? YES NO
31) Prolonged loss of appetite? YES NO

Genitourinary

32) Pain or burning when you urinate? YES NO
33) Urinating more frequently than normal? YES NO
34) Getting up every night to urinate? YES NO
35) Leaking urine by mistake? YES NO
36) Passed blood, stones, gravel, protein or albumin in your urine? YES NO
37) Irregular menstrual periods? YES NO
38) Abnormally heavy or painful menstrual periods? YES NO
39) Severe vaginal discharge? YES NO
40) Painful or impossible sexual intercourse? YES NO
41) Trouble with erections? YES NO
42) History of sexually transmitted diseases like syphilis, Chlamydia, HIV? YES NO

Musculoskeletal

43) Stiff, swollen or painful joints? YES NO

Skin Threats

44) Skin rashes, lumps, itching, changing moles? YES NO
45) Breast pain or lumps? YES NO
46) Breast nipple discharge (other than when breast-feeding)? YES NO

Neurological

47) Severe frequent headaches? YES NO
48) Loss of strength or feeling in any part of your body? YES NO
49) Constant numbness or tingling in any part of your body? YES NO
50) Fits, seizures or convulsions? YES NO
51) Loss of consciousness? YES NO

Psychological

52) Abnormally nervous; panic attacks? YES NO
53) Ever become seriously depressed? YES NO
54) Frequent trouble falling or staying asleep? YES NO

Endocrine

55) Thyroid problems or goiter? YES NO

Please comment on any "YES" answers: ____________________

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