Association of Specialty Physicians, Inc.

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HEALTH QUESTIONNAIRE

Name ______________________ Birth Date ____________ Age ______ Date __________

Current Problem ______________________________ Referring Doctor ________________

FAMILY HISTORY

	AGE	LIVING/DECEASED	PRESENT HEALTH OR CAUSE OF DEATH
Mother			
Father			
Sisters ( )			
Brothers ( )			
Children ( )			

HAS ANY BLOOD RELATIVE HAD:	Yes	No	**HAVE YOU EVER HAD THE FOLLOWING X-RAYS:**	Yes	No
Cancer			Chest		
Tuberculosis			Stomach		
Diabetes			Colon		
Heart Trouble			Gallbladder		
High Blood Pressure			Extremities		
Stroke			Back		
Epilepsy			EKG		
Mental Illness			List any others:		
Suicide					
ARE YOU ALLERGIC TO:			**DO YOU HAVE OR HAVE YOU HAD?**		
Penicillin			Fainting Spells		
Sulfa			Convulsions		
Merthiolate			Paralysis		
Adhesive Tape			Headaches		
Tetanus Antitoxin			Chronic Cough		
List any others:			Chest Pain		
DO YOU HAVE OR HAVE YOU HAD:			Spitting up Blood		
Measles			Night Sweats		
Mumps			Swelling of Extremities		
Chicken Pox			Indigestion		
Whooping Cough			Gallstones		
Pneumonia			Colitis		
Rheumatic Fever			Rectal Bleeding		
Heart Disease			Constipation		
Kidney Disease			Diarrhea		
Anemia			Change in Bowel Habit		
Jaundice			Weight Loss		
Epilepsy			Weight Gain		
Tuberculosis			Head Injury		
Diabetes			Broken Bones		
Liver Disease			Blood Transfusion		
High Blood Pressure					
Stroke					
Cancer					

CONTINUED ON BACK

HAVE YOU HAD ANY OPERATIONS: PLEASE LIST	DATE
ARE YOU CURRENTLY ON ANY MEDICATIONS: PLEASE LIST	DOSAGE

DO YOU:

Sleep well . . . . ☐ Yes ☐ No

Use alcoholic beverages . . . . ☐ Yes ☐ No

Do you currently use tobacco . . . . ☐ Yes ☐ No

How much do you use daily ___________________

Did you ever use tobacco. ☐ Yes ☐ No

How long did you smoke and when did you quit?

____

MENSTRUAL HISTORY:

Age of Onset _________ Days in Cycle _______ Days of Flow ____

Date of Last Period ______________ Cramps: ☐ Yes ☐ No

PREGNANCIES:

How Many Pregnancies _________ How Many Deliveries ________

How Many Miscarriages _________ Did You Nurse ☐ Yes ☐ No

Any complications ____

____

IS THERE ANY OTHER PERTINENT INFORMATION WE SHOULD KNOW ABOUT THAT IS NOT LISTED ABOVE, IF SO PLEASE LIST: