PRELIMINARY HEALTH SCREENING QUESTIONNAIRE

These questions are an important part of your health history. Your Doctor will review your answers with you. Please finish this before the doctor sees you.

Name _____ Date _____

Date of Birth _____ Age _____ Job _____

Check one: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Spouse's name _____ Job _____

Have you had any operations? List the dates and types of surgeries.

_____

_____

_____

Have you been hospitalized for any other reason? List the date and type of illness.

_____

_____

_____

What medicines do you take? (Include such things as vitamins, asprin, laxatives and birth control pills.)

_____

_____

_____

Have you ever had a blood transfusion _____ Any reaction to it? _____

Have you ever had a bad reaction to medicine? _____

If yes, what kind? _____

Do you have other allergies? _____

How much do you smoke? _____ For how long? _____

How much do you drink? _____ For how long? _____

REVIEW OF SYSTEMS

General	Yes	No
Have you lost or gained weight in the last year?	☐	☐
Do you have night sweats?	☐	☐
Have you had a change in your appetite?	☐	☐
Skin		
Do you have any skin sores that have not healed?	☐	☐
Have you noticed any large glands or lumps anywhere on your body?	☐	☐
Are you troubled by a skin rash or itching?	☐	☐
HEENT		
Do you have trouble hearing people speak to you?	☐	☐
Have you had any trouble with your vision?	☐	☐
Has your voice changed or become hoarse?	☐	☐
Breasts		
Have you had any lumps or discharge from your breasts?	☐	☐
Resp.		
Do you get short of breath easily?	☐	☐
Have you or anyone you know had tuberculosis?	☐	☐
Do you have a cough?	☐	☐
Do you bring up sputum or blood?	☐	☐
Have you ever had asthma?	☐	☐
Have you ever been told an x-ray picture of your chest was not normal?	☐	☐
CV		
Have you ever had high blood pressure?	☐	☐
Have you ever had rheumatic fever?	☐	☐
Have you ever had heart trouble?	☐	☐
Have you ever been told you had a heart murmur?	☐	☐
Do you sleep propped up or do you wake up at night with shortness of breath?	☐	☐
Do you ever have pain or discomfort in your chest or neck or arms?	☐	☐
Do you have swelling of the ankles?	☐	☐
GI		
Have you noticed any change in your bowel movements in the past year?	☐	☐
Have you ever had red blood in your stools?	☐	☐
Have your stools ever been black as tar?	☐	☐
Have you ever had yellow jaundice or hepatitis?	☐	☐
Have you had heart burn or indigestion?	☐	☐
Do you ever have pain in your stomach or abdomen?	☐	☐
Have you ever had an ulcer?	☐	☐
Have you ever had gall bladder problems	☐	☐

REVIEW OF SYSTEMS, continued

GU	Yes	No
Do you have to urinate often?	☐	☐
Does your urine burn or hurt when you urinate?	☐	☐
Have you ever had a kidney stone?	☐	☐
Have you ever had an infection in your kidney or bladder?	☐	☐
Do you have any problems with sexual relations?	☐	☐
Have you ever had syphilis or bad blood?	☐	☐
Have you ever had gonorrhea or clap?	☐	☐
Do you sometimes lose control of your bladder?	☐	☐

For women:

Age of first menstrual period? _____

How often do you have periods? _____ Are they regular	☐	☐
How long do they last? _____		
Do you have a discharge from your vagina?	☐	☐
What kind of birth control do you use? _____		
How many times you been pregnant? _____		
Did you have any trouble with any of your pregnancies?	☐	☐
If yes, please explain? _____		
_____ ☐ _____		
Have you had change of life (menopause)?	☐	☐
If yes, at what age? _____		

Endocrine		
Have you ever had a large thyroid gland or goiter in your neck?	☐	☐
Has anyone told you that you have diabetes or sugar in you urine?	☐	☐
If yes, please explain? _____		

Hematopoietic		
Have you ever had trouble with your blood?	☐	☐
Do you bleed easily?	☐	☐

Neuro		
Do you have frequent or severe headaches?	☐	☐
Have you ever have fits or convulsions?	☐	☐
Do you have trouble getting to sleep?	☐	☐
Do you often feel unhappy or depressed?	☐	☐
Do you often feel unhappy or depressed?	☐	☐
Have you ever passed out or lost consciousness?	☐	☐
Have you ever been treated for psychiatric illness or nervous condition?	☐	☐

MS		
Do you have any joint pains or arthritis?	☐	☐
Do you have night cramps?	☐	☐
Do you have cramps in your legs when you walk?	☐	☐

Are there any other medical problems you think the doctor should know about?	☐	☐

If yes, please explain _____

_____

Which, if any, of the following diseases have occurred in your family? Indicate which relative next to each disease.

Diabetes _____

High Blood Pressure _____

Cancer _____

Thyroid Disease _____

Stroke or Bleeding in Brain _____

Kidney Disease _____

Arthritis _____

Blood Diseases _____

Heart Disease _____

Obesity (Overweight) _____

Nervous or Mental Problems _____

Does anything else run in the Family? .....Yes ☐ No ☐

If yes, please explain _____

_____

_____

_____

_____

NUTRITION

Do you have a poor appetite?
☐ Yes ☐ No

Do you have trouble swallowing?
☐ Yes ☐ No

Have you involuntarily lost or gained 10 pounds overthe last 6 months?
☐ Yes ☐ No

PHYSICAL ACTIVITY

Have you notice difficulty with bathing dressing, etc.?
☐ Yes ☐ No

Have you noticed difficulty with walking or standing?
☐ Yes ☐ No

Have you had a decline in any other physical function
☐ Yes ☐ No

PAIN

Do you have pain?
☐ Yes ☐ No

If "YES" please rate the pain on a scale of 0-10
(Please circle your responses below):

◯ = no pain
◯ = mild pain
◯ = moderate pain
◯ = severe pain
◯ = very severe pain
◯ = worst possible pain

Where is the pain?

Describe the pain:

What have you done in the past to relieve the pain?