HEALTH QUESTIONNAIRE

Name:

Current Treatment

Do you have any current medical problems? Describe:	Is it being treated? □Yes □No If yes, by whom?
What Medications are you taking? Drug Dose/Frequency	Who is your Primary Care Physician? Name:__________________________ Phone/Location:______________________ Have you ever had a drug allergy or sensitivity? □Yes □No If yes, to what drug? ______________________
When was your last physical exam?	What is your Height Weight

Family Medical History

Have any of your blood relatives suffered from the following diseases or problems?

Disease	Yes	No	Which Relative
High Blood Pressure	□Yes	□No	
Heart Disease	□Yes	□No	
Stroke	□Yes	□No	
Diabetes	□Yes	□No	
Cancer	□Yes	□No	
Thyroid Disease	□Yes	□No	
Kidney Disease	□Yes	□No	
Anemia	□Yes	□No	
Obesity	□Yes	□No	
Emotional Problems	□Yes	□No	
Addiction	□Yes	□No	
Other (specify)	□Yes	□No	

Personal Medical History

Do you have now, or have you ever had any of the following disease or symptoms?

High Blood Pressure	□Yes	□No	Ulcer	□Yes	□No	Poor Appetite	□Yes	□No
Heart Disease	□Yes	□No	Head Injuries	□Yes	□No	Weight Gain	□Yes	□No
Stroke	□Yes	□No	Seizure	□Yes	□No	Weight Loss	□Yes	□No
Diabetes	□Yes	□No	Kidney Disease	□Yes	□No	Lack of Energy	□Yes	□No
Cancer	□Yes	□No	Jaundice/Liver	□Yes	□No	Excessive Thirst	□Yes	□No
Asthma	□Yes	□No	Anemia	□Yes	□No	Sleep Problems	□Yes	□No
STD	□Yes	□No	Thyroid	□Yes	□No	Skin Rash	□Yes	□No
Muscle/Joint Pain	□Yes	□No	Fainting	□Yes	□No	Chest Pain	□Yes	□No
Numbness	□Yes	□No	Eye Pain	□Yes	□No	Wheezing	□Yes	□No
Dizziness	□Yes	□No	Vision Issues	□Yes	□No	Urination Issues	□Yes	□No