ASSOCIATED HEALTH CARE, LLC

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HEALTH QUESTIONNAIRE (PLEASE PRINT) Today's Date ____________________ Age________ Circle: Female / Male

Name ____ e-mail ____

Address ______________________________________ City/State/Zip ______________________________________

Home Phone _______________ Work Phone _________________ Cell________________ Date of Birth ______________

What is today's complaint? ___________________________________

____

____

HISTORY OF PAST ILLNESSES

Measles……………………………………………………………….. Yes No

Mumps………………………………………………………………….. Yes No

Chicken Pox………………………………………………………….. Yes No

Rheumatic Fever or Heart Disease……………………………………. Yes No

Venereal Disease (Syphllis, Gonorrhea, Herpes, etc)……………………… Yes No

Congenital abnormalities………………………………………………. Yes No

Other serious illnesses or injuries…………………………………….. Yes No

If yes, describe ____

____

Were you ever hospitalized?………………………………………… Yes No

If yes, describe ____

Have you ever had surgery?…………………………………………… Yes No

If yes, list with age or year of operation__________________________

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Do you have any implants?……………………………………………….. Yes No

Do you drink alcoholic beverages?……………………………………… Yes No

_____ Rarely _____ Moderately ____ Daily

Do you use tobacco?……………………………………………………… Yes No

____Cigarettes ____Cigars ____ # per day

Do you use recreational drugs?…………………………………………… Yes No

Are you exposed to fumes, dust, solvents on the job or at home?……………………………………………… Yes No

Are you now taking any medications or vitamin supplements?……………………………………………….. Yes No

If yes, please list: ____

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Have you or any family member ever had:

Cancer…………………………………………………………………… Yes No

Tuberculosis…………………………………………………………. Yes No

Diabetes………………………………………………………………………. Yes No

Heart Trouble or High Blood Pressure…………………………………….. Yes No

Stroke……………………………………………………………………… Yes No

Convulsions……………………………………………………………….. Yes No

Insanity…………………………………………………………………….. Yes No

Bleeding tendency……………………………………………………. Yes No

Gout or other arthritis………………………………………………………… Yes No

Other, please list: ____

____

SYSTEMIC REVIEW: Do you have any of the following?

Skin:

Hives, eczema, rash, boils, warts……………………………………….. Yes No

Head-Eye-Ears-Nose-Throat:

Headaches………………………………………………………………… Yes No

Do you wear glasses?…………………………………………………….. Yes No

Itching eyes or nose……………………………………………………….. Yes No

Sneezing, nosebleeds or runny nose………………………………………… Yes No

Chronic sinus trouble……………………………………………………….. Yes No

Impaired hearing…………………………………………………………….. Yes No

Dizziness or transient episodes of unconsciousness………………….. Yes No

Respiratory:

Chronic or frequent cough…………………………………………… Yes No

Difficulty breathing, asthma, emphysema, wheezing…………… Yes No

Cardiovascular:

Chest pain or angina pectoris……………………………………… Yes No

Shortness of breath when walking or lying down………………… Yes No

Difficulty walking two blocks……………………………………… Yes No

Heart trouble, heart attack, heart murmur………………………… Yes No

High blood pressure or Low blood pressure……………………… Yes No

Swelling of hands, feet or ankles…………………………………… Yes No

Awakening in the night smothering……………………………… Yes No

Gastrointestinal:

Vomiting blood or food……………………………………………… Yes No

Bleeding with bowel movements or black stools………………… Yes No

Hemorrhoids, piles or painful bowel movements………………… Yes No

Recent changes in bowel habits…………………………………… Yes No

Frequent diarrhea or constipation………………………………… Yes No

Heartburn, indigestion, ulcers, colitis…………………………. Yes No

Genitourinary:

Frequent or nighttime urination…………………………………… Yes No

Burning or painful urination……………………………………… Yes No

Blood in urine……………………………………………………… Yes No

Gynecological:

Age period started __________ How long do periods last ____ days

Number of pregnancies _______ Number of miscarriages _________

Number of children ________ Ages _________________________

Date of last pap smear and results ______________________________

First day of last period ____

Frequency of periods, every __________ days

Any pain with periods……………………………………………… Yes No

Locomotor-Musculoskeletal:

Weakness of muscles or joints…………………………………… Yes No

Any difficulty walking or exercising……………………………… Yes No

Hematologic:

Anemia or Hemophilia……………………………………………… Yes No

Phlebitis……………………………………………………………… Yes No

Endocrine:

Thyroid Disease……………………………………………………… Yes No

Hormone Therapy…………………………………………………… Yes No

Have you become colder than before…………………………… Yes No

Has your skin become drier……………………………………… Yes No

Recent weight change……………………………………………… Yes No

ALLERGIES AND SENSITIVITIES

Is there a history of skin reaction or other abnormal reaction to or sickness following injection or oral administration of:

Antibiotics: (penicillin, sulfa, etc)………………………………… Yes No

Narcotics: (morphine, codeine, demerol, etc)…………………… Yes No

Anesthesia: (novocaine, lidocaine, etc)…………………………… Yes No

Pain Remedies (aspirin, Empirin, Tylenol, etc)…………………… Yes No

Vaccines (smallpox, tetanus, etc)………………………………… Yes No

Iodine or merthiolate………………………………………………… Yes No

Adhesive tape, plastics, etc………………………………………… Yes No

Any foods: (eggs, milk, chocolate, caffeine, etc)………………… Yes No

Other: Please list: ____