HEALTH QUESTIONNAIRE

Name: ______________________________ **Date of Birth:** ______________
Email: ______________________________ **Mobile Number:** ______________
Reason for Visit: Pap / Physical / Other ____________ **Place of Birth:** ______________
Current prescription medications, vitamins or supplements:

____
Allergies: ____

PAST MEDICAL HISTORY

*Please check if **YOU** have or had the following:*

☐ Measles ☐ Asthma ☐ Heart attacks
☐ Mumps ☐ Emphysema ☐ Rheumatic fever / heart disease
☐ Chickenpox ☐ Strokes ☐ Sexually transmitted disease(s)
☐ Birth defects ☐ Diabetes ☐ Tuberculosis
☐ Cancer type: ______________________________
☐ Injuries ☐ Broken bones details/date: ______________________
☐ Head concussions or injuries details/date: ______________
☐ Hospitalization(s) ______________________________
☐ Anesthesia ☐ Local ☐ Regional ☐ General ☐ Other / Unknown
☐ Operations ______________________________
☐ Car accident(s) date(s): ______________________________
☐ Other serious conditions ______________________________

FAMILY HISTORY

*Please check if **any blood relative** has ever had:*

☐ Breast cancer (who: ____________) ☐ Colon cancer (who: ________________)
☐ Other cancers (______________) ☐ Mental illness (anxiety / depression / other)
☐ Bleeding tendencies ☐ Osteoarthritis / Gout
☐ Diabetes ☐ Seizures
☐ Heart disease / heart attacks ☐ Strokes
☐ High blood pressure ☐ Tuberculosis
☐ High cholesterol ☐ Other ______________________

RELATIVE	IF LIVING		IF DECEASED	
	Age	Health	Age	Cause of Death
Father				
Mother				
Sibling(s) M/F				
M/F				
Spouse				
Children M/F				
M/F				

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other
Are you sexually active? ☐ Yes ☐ No If yes, ☐ with males ☐ with females ☐ with both
Are you living with your spouse/partner? ☐ Yes ☐ No Is your sex life satisfactory? ☐ Yes ☐ No
Are there dependents at home? ☐ Yes ☐ No Children / Grandchildren / Other
Do you drink alcohol? ☐ Yes ☐ No Amount? ______________________
Do you smoke now? ☐ Yes ☐ No Amount? ______________________
Did you ever smoke? ☐ Yes ☐ No Amount / Quit date? ______________
Do you use drugs? ☐ Yes ☐ No How much / often? ______________
Do you have pets? ☐ Yes ☐ No Please list: ______________________
Do you exercise regularly? ☐ Yes ☐ No Do you have an advance directive? ☐ Yes ☐ No
Are you employed? ☐ Full-time ☐ Part-time ☐ Unemployed Occupation: ____________
Time lost due to health reasons: In past 6 mos? ______ past yr: ______ past 5 yrs: ______

(OVER PLEASE)

REVIEW OF SYSTEMS

*Please **CIRCLE** if you have any of the following **NOW**:*

GENERAL: Fever Chills Weight loss Weight gain Fatigue Appetite change Insomnia
SKIN: Acne Jaundice Hives Eczema Psoriasis Rashes Boils Abnormal pigmentation
HEAD/EYES/EARS/NOSE/THROAT: Headaches Eye disease or injury Glasses Contacts
Double vision Blurry vision Glaucoma Itchy eyes Runny nose Sneezing
Nosebleeds Chronic sinus trouble Ear disease Poor hearing Dizziness
NECK: Stiffness Enlarged glands Thyroid trouble
RESPIRATORY: Frequent colds Spitting up blood Cough Asthma/Wheezing Emphysema
Difficulty breathing Shortness of breath Pain with breathing Pleurisy Pneumonia
CVS: Chest pain Shortness of breath at rest / with activity Awakening in night smothering
Difficulty walking two blocks Swelling of hands / feet / ankles High blood pressure
Heart murmur Valvular heart disease Palpitations
DIGESTIVE SYSTEM: Food sticks in throat Heartburn/Indigestion Ulcer Nausea Vomiting
Vomiting blood Gallbladder disease Liver trouble Hepatitis Cramping Gas/Bloating
Diarrhea Constipation Painful stools Hemorrhoids Bloody stools Black stools
GYNECOLOGICAL: Age periods started: ____ How long do periods last? ____________________
Frequency of periods: Every _____________ days Painful periods PMS Menopause
Birth control _________________ Hysterectomy (date / reason: ________________________)
Number of pregnancies _______ Number of abortions/miscarriages ____________________
Date of last period _________________ Last Pap _________________ Normal / Abnormal
Date of last mammogram ______________________________________ Normal / Abnormal
GENITOURINARY: Kidney stones Loss of urine Frequent urination Burning/painful urination
Blood in urine Vaginal / Urethral discharge Circumcised? Y / N Testicular pain / swelling
MUSCULOSKELETAL: Varicose veins Weakness of muscles or joints Difficulty walking
Pain or swelling of joints Back pain (where? __________________________chronic? Y / N)
Scoliosis Pain in buttock/calves while walking, relieved with rest
ENDOCRINE: Thyroid disease Change in hat/glove size Hair loss Always hot / cold
Current wt ___________ Current height ___________ Dry skin Coarse hair
HEMATOLOGIC: Slow healing Easy bruising Anemia Phlebitis Blood Clots
NEUROPSYCHIATRIC: Lightheadedness Fainting spells Numbness Tingling Paralysis
Weakness Convulsions/Seizures Under a lot of stress Anxiety Depression Bipolar
Suicide Attempts Disinterest in usual activities Hopelessness Worthlessness
Poor concentration Anorexia Bulimia
PREVENTIVE: Last tetanus shot ________________ Last flu shot __________________________
Last pneumonia shot ____________________ Last screen for colon cancer ____________
Last shingles shot ______________________ Last prostate check / PSA _____________
Name & number of your dentist ____

Patient's signature: ____ Date: ______________

Reviewed by: ____ Date: ______________

Ann L. Mai, M.D. - Diplomate, American Board of Internal Medicine
4950 Barranca Parkway, Suite 207 Irvine, CA 92604