HEALTH QUESTIONNAIRE

Date: _____Patient Name:_____ Age:___ Phone: _____

HISTORY OF PRESENT ILLNESS:

Measles	☐Yes	☐No	Mumps	☐Yes	☐No
Diabetes	☐Yes	☐No	Chicken Pox	☐Yes	☐No
Rheumatic	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Venereal Disease	☐Yes	☐No	Stroke	☐Yes	☐No

If yes, explain:

Have you had an serious illness?	☐Yes	☐No	_____
Have you ever been hospitalized or	☐Yes	☐No	_____
Have you had any surgeries?	☐Yes	☐No	_____
Have you had any broken bones?	☐Yes	☐No	_____
Have you had any head injuries?	☐Yes	☐No	_____

FAMILY HISTORY:

Relative	Age	Health	If deceased, cause
Father			
Mother			
Brother/Sister			
Brother/Sister			
Daughter/Son			
Daughter/Son			
Spouse			

HAS ANY BLOOD RELATIVE EVER HAD:

Cancer	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Diabetes	☐Yes	☐No	Heart Trouble	☐Yes	☐No
Convulsions	☐Yes	☐No	Suicide	☐Yes	☐No
Mental Illness	☐Yes	☐No	Bleeding Tendency	☐Yes	☐No
Gout or other Arthritis	☐Yes	☐No	Other:		

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Are you living with your spouse? ☐Yes ☐No

Is your sex life satisfactory? ☐Yes ☐No

Do you have any dependents at home? ☐Yes ☐No

Where were you born? _____

Alcohol consumption: ☐Never ☐Rarely ☐Moderately ☐Daily

Tobacco use: Smoke _____ packs/day ☐Non-Smoker

If non-smoker: Ever smoked? ☐Yes ☐No If yes, how many years? ____ years

Are you exposed to fumes, dust or solvent? ☐Yes ☐No

If yes, list:_____

Occupation: _____

ALLERGY HISTORY:

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

Penicillin or other antibiotics	☐Yes	☐No	Morphine, codeine, Demerol	☐Yes	☐No
Novocain or other anesthesia	☐Yes	☐No	Aspirin or other pain remedies	☐Yes	☐No
Sulfa drugs	☐Yes	☐No	Tetanus antitoxin	☐Yes	☐No
Adhesive tape	☐Yes	☐No	Iodine or Marthiolate	☐Yes	☐No

Food or other drugs? _____

List all drugs you are currently taking :_____

Lamia L. Gabal-Shehab MD Inc. Patient Signature: _____ Date: _____

SYSTEM REVIEW

General			Hematological		
Recent weight change?	Yes	No	Are you slow to heal after cuts?	Yes	No
Have you been in good general health			Blood disease	Yes	No
most of your life?	Yes	No	Phlebitis	Yes	No
			Anemia	Yes	No
Head-Eyes-Ear-Nose-Throat			Have you ever had difficulty with bleeding		
Eye disease or injury	Yes	No	excessively after tooth extraction or surgery?	Yes	No
Do you wear glasses?	Yes	No			
Double vision	Yes	No	Cardiovascular		
Headaches	Yes	No	Chest pain or angina pectoris	Yes	No
Glaucoma	Yes	No	Difficulty walking two blocks	Yes	No
Itching eyes	Yes	No	Heart trouble or heart attack	Yes	No
Sneezing or runny nose	Yes	No	High blood pressure	Yes	No
Nosebleeds	Yes	No	Swelling of hands, feet or ankles	Yes	No
Chronic sinus trouble	Yes	No	Heart murmur	Yes	No
Ear disease	Yes	No	Shortness of breath lying down	Yes	No
Impaired hearing	Yes	No			
Dizziness	Yes	No	Genitourinary		
			Leakage of urine	Yes	No
Neck			Frequent urination	Yes	No
Stiffness	Yes	No	Nighttime urination	Yes	No
Thyroid trouble	Yes	No	Burning or frequent urination	Yes	No
Enlarged glands	Yes	No	Blood in urine	Yes	No
			Kidney trouble	Yes	No
Respiratory			Urinary tract infections (UTIs)	Yes	No
Upper respiratory infections	Yes	No			
Spitting up blood	Yes	No	Endocrine		
Chronic or frequent cough	Yes	No	Thyroid disease	Yes	No
Asthma or wheezing	Yes	No	Hormone therapy	Yes	No
Difficulty breathing	Yes	No	Cramping or pain in abdomen	Yes	No
Any trouble with lungs	Yes	No	Have you become colder than before or skin		
Pleurisy or pneumonia	Yes	No	become drier?	Yes	No
Gastrointestinal			Neuropsychiatric		
Peptic ulcer	Yes	No	Have you ever had a psychiatric check?	Yes	No
Vomiting blood or food	Yes	No	Have you ever been advised to see a psychiatrist?	Yes	No
Gallbladder disease	Yes	No	Have you ever had:		
Liver trouble	Yes	No	Convulsions?	Yes	No
Hepatitis	Yes	No	Fainting spells?	Yes	No
Painful bowel movements	Yes	No	Paralysis?	Yes	No
Bleeding with bowel movements	Yes	No			
Black stools	Yes	No	Gynecological (Women)		
Hemorrhoids or piles	Yes	No	Age period started _____		
Recent change in bowel habits	Yes	No	Pain with periods	Yes	No
Frequent diarrhea	Yes	No	Date of last period _____		
Heartburn or indigestion	Yes	No	Frequency of periods _____		
Does food stick in your throat?	Yes	No	Number of pregnancies _____		
			Number of children _____		
Musculoskeletal			Number of miscarriages _____		
Varicose veins	Yes	No			
Weakness of muscles or joints	Yes	No	Skin Disease		
Any difficulty walking	Yes	No	Jaundice	Yes	No
Any pain in calves or buttocks with walking?	Yes	No	Hives, eczema, or rashes	Yes	No
Relieved with rest?	Yes	No	Abnormal pigmentation	Yes	No

Lamia L. Gabal-Shehab MD Inc. Patient Signature: _____ Date: _____