Lower Lights
Christian Health Center

Health Questionnaire

To be completed by the Patient- Please Print

Name……………………………………………….. **Today's date………………………………**
Date of Birth………………. **Age:…………………**
Height………………. **Weight…………….**

Drug Allergies……………………………………………………………………………

Please list in order of importance, the present health concerns , symptoms, or problems you are experiencing:

Have you had a diagnosis of the following? Circle Yes or No for each ;leave blank if uncertain

AIDS or HIV	Y	N	Heart Valvular Disease	Y	N	Osteoporosis	Y	N
Anemia	Y	N	Hepatitis	Y	N	Gall Bladder Disease	Y	N
Angina	Y	N	List type……………………………			Glaucoma	Y	N
Atrial Fibrillation	Y	N	Hypertension	Y	N	Epilepsy	Y	N
Asthma	Y	N	High Cholesterol	Y	N	Stroke	Y	N
Blood Clots	Y	N	Inflam. Bowel Disease	Y	N	Thyroid Disease	Y	N
Coronary Artery Dis.	Y	N	Irritable Bowel Disease	Y	N	Cancer	Y	N
COPD	Y	N	Kidney Disease	Y	N	List type…………………………		
Diabetes	Y	N	Liver Disease	Y	N			
Heart Disease	Y	N	Migraines	Y	N			

Please list any other health problems you have had:…………………………………………………………..
……

SURGICAL HISTORY

Have you ever had the following surgeries? Please circle the surgery and list the year:

	Year		**Year**		**Year**
Appendectomy		Gastric Bypass		Hysterectomy	
Angioplasty		Hernia Repair		Mastectomy	
Heart Stent		Hip replacement		Gall Bladder surgery	
Arthroscopy		Knee replacement		Ovary Removal	
Back Surgery		LASIK		Breast Surgery	
Blood Transfusion		Liver Biopsy		Bowel resection	
Carpal Tunnel Release		Pacemaker		Tubal ligation	
Coronary Bypass		Thyroid surgery		Fibroid Surgery	
Cataract extraction		Tonsillectomy		ORIF	
Colectomy		C. Section			
Colostomy		D and C			

Other:………
……..

Hospitalization: If you have been in the hospital overnight, other than the surgeries listed above, please list the illness and the year. Do not include normal pregnancies……………………………………….
………

FAMILY HISTORY:

Has any blood relative had any of the folowing? (Circle Yes or No; leave blank if unsure)

	Relationship		Relationship
ADD/ADHD		Irritable Bowel	
Alcohol abuse		Learning disability	
Allergies		Peripheral vascular dis.	
Alzheimer's		Kidney disease	
Asthma		Migraines	
Blood disorder		Mental Illness	
Depression		Obesity	
Eczema		Osteoporosis	
High Cholesterol		Epilepsy	
Hypertension		Thyroid disorder	
Developmental Delay		Genetic Disease	

Cancer: (list type and relationship)……………………………………………………………………………………………………

For the following Diseases: list the relationship and the age of onset, or whether it was the cause of death:

Diabetes	Age…………..	Relationship	Cause of death?	Y	N
Stroke	Age…………..	Relationship	Cause of death?	Y	N
Heart Attack	Age…………..	Relationship	Cause of death?	Y	N
Coronary artey disease	Age………….	Relationship	Cause of death?	Y	N

List your medications:

Times/Day…….
……….
………

Social History

Tobacco	Y	N	Packs per day:…………………………	for	………………………..	years
Alcohol	Y	N	Drinks per week:……………….	Type:	………………………..	
Caffeine	Y	N	Cups per day:…………………….	Type:	………………………..	
illegal drugs	Y	N	Type:…………………………………………………………………………………………			

The last time you had a (list year):

Flu vaccine…………………..	Tetanus vaccine………………….	Hepatitis vaccine……………………
Pneumonia vaccine……………………	TB test…………………………..	Rubella vaccine…………………..
Stool blood test………………	Mammogram…………………….	Colonoscopy…………………….
Eye exam……………………..	PAP………………………	

FOR WOMEN ONLY:

Age of first menstrual period:………………………………. Date of last menstrual period:…………………….

Use of birth control? Y Y N Type…………………………………………………………………………………………

Number of pregnancies?...............Number of live births?...............Number of premature?.............

Number of full term?...................Number of abortions?...............Number of miscarriages?.............

Name……………………………………………………. DOB……………………………………………………….