Lower Lights
Christian Health Center

Health Questionnaire

To be completed by patient, please print.

Today's Date _____

Name _____ **Date of birth** _____

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	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.

Disease	Year	Disease	Year	Disease	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					

Name: _____ **DOB:** _____

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 following? (Circle Yes or No; leave blank if unsure)

Disease	Relationship	Disease	Relationship
ADD/ADHD		Irritable Bowel	
Alcohol Abuse		Learning Disability	
Allergies		Peripheral Vascular Disease	
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:

Disease	Age	Relationship	Cause of Death?	Yes	No
Diabetes					
Stroke					
Heart Attack					
Coronary Artery Disease					

List your medications:

Times/Day _____

Social History

Tobacco	Y	N	Packs Per Day: _____	for _____ year's
Alcohol	Y	N	Drinks Per Week: _____	Type: _____
Caffeine	Y	N	Cups Per Day: _____	Type: _____
Illegal Drugs	Y	N	Type: _____	

Vaccine(s)

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 N	Type: _____	
Number of Pregnancies? _____	Number of Live Births? _____	Number of premature? _____
Number of Full Term? _____	Number of Abortions? _____	Number of Miscarriages? _____