Pulmonary Medicine, Infectious Disease and Critical Care Consultants

Health Questionnaire

Fill Out All Four Pages

Name: **Birthdate:** **Date:**

In order to give you the best possible medical care, please complete as much of this questionnaire as possible.

Summary of current medical problem:____

Past medical problems (diabetes, high blood pressure, gout, etc.):

Prior hospitalizations:

Current medications and dosages:

What has been your general health in the past? ☐Good ☐Fair ☐Poor
What is your present state of health? ☐Good ☐ Fair ☐Poor
How many days have you been absent from work in the past year because of illness or injury?

When was your last visit to the family physician? Reason?
Eye examination? Dentist?

Please indicate whether you have had any of the following conditions.
Explain "yes" answers below.

PROBLEM	YES	NO	PROBLEM	YES	NO
Eczema or skin trouble			Frequent or severe sore throats		
Recurrent prolonged boils			Recent Hoarseness or voice change		
Itching			Repeated urge to clear your throat		
Hives			Goiter or thyroid trouble		
Excessive sweating			Frequent swollen glands in neck		
Skin growth, tumor or skin cancer			Lumps, tumor or growths in breasts		
Chemical or drug rash			Discharge or bleeding from nipples		
Nail or hair problems			Soreness or tenderness in breasts		
Easy bruising			Frequent cough or cigarette cough		
Frequent headaches			Frequent heavy chest colds		
Migraine attacks			Pain in chest on breathing		
Dizziness (light-headedness)			Wheezing, asthma		
Head injury with unconsciousness			Coughing up blood		
Concussion			Raising of sputum or phlegm daily		
Poor vision requiring glasses or			Pneumonia, pleurisy or tuberculosis		
contact lenses			Recent close association with a		
Vision correctable to normal, both eyes?			case of active tuberculosis		
Do you wear contact lenses?			Collapsed lung, fluid or pus in lungs		
Frequent eye infections			Any other lung or bronchial problem		
Blurring of vision			More shortness of breath than		
Double vision			others your age on exertion or activity		
Serious eye injury			High blood pressure		
Color blindness			Anemia or blood disorders		
Cataracts			Heart trouble or heart murmur		
Glaucoma			Tightness, pain, heaviness,		
Temporary loss of vision			squeezing or pressure around heart		
Difficulty reading			Fast, racing, irregular pulse		
Swelling of eyelids			Palpitations, skipped beats,		
Loss of hearing			fluttering or prodding in your chest		
Ringing or buzzing in ears			Swelling of feet, ankles or legs		
Frequent ear infections			Trouble breathing when lying flat		
Mastoid trouble			Rheumatic or scarlet fever		
Ruptured ear drum			Painful whitish or bluish discolora-		
Discharge or draining from ears			tion or tinges of toes when cold		
Chronic itching of ears			Phlebitis,varicose or other vein trouble		
Hay fever			Pain in leg muscles when walking		
Loss of smell			Change in appetite or food habits		
Severe sinus trouble			Trouble swallowing		
Frequent nosebleeds			Hernia or rupture		
Difficulty breathing through your nose			Yellow jaundice or hepatitis		
Painful, swollen or bleeding gums			Sour stomach, indigestion or heartburn		
False teeth or dentures			Trouble from any foods or beverages		
Loss of taste			Treatment for ulcers, gall bladder		
Repeated sores or ulcers in mouth			trouble, intestinal or bowel conditions		
Prolonged tongue soreness			Nausea, vomiting, diarrhea or constipation		

Please indicate whether you have had any of the following conditions.
Explain "yes" answers on the bottom or back of this sheet.

PROBLEM	YES	NO	PROBLEM	YES	NO
Vomiting of blood; black, tarry or bloody bowel movements			Difficulty in walking or keeping your balance		
Change in bowel or toilet schedule			Numbness, tingling or “pins and		
Piles, hemorrhoids or rectal trouble			needles" of hands, feet, arms or legs		
Kidney stones, nephritis, kidney or			Nervous or emotional troubles		
bladder infection			Trouble sleeping		
Pain or burning on urination			Trouble concentrating or making decisions		
Need to get up regularly at night to urinate			Frequent bothersome or prolonged		
Need to urinate frequently			periods of worrying		
Gonorrhea, syphilis or other venereal disease			Exhaustion at the end of the working day		
Pus, sugar, albumin or blood in urine			Have you been told that you have		
Trouble starting or stopping urination			diabetes?		
(*For men only*) Trouble with testicles			Often discouraged, depressed,		
or prostate, discharge from penis			upset, tense or feeling blue		
Difficulty with erection			Are you on a special diet?		
Slipped disc, lumbago, chronic back			Hair loss		
pain or sciatica			Hair growth		
Arthritis, rheumatism, stiffness,			Change in skin pigment		
swelling,redness or pains in any joints			*(For women only):*		
Gout			Date of last menstrual period		
Repeated attacks of bursitis			Excessive menstrual flow or		
Prolonged foot trouble			bleeding between periods		
Fractures, broken bones or serious injury			Frequent or irregular menstrual periods		
Dislocation of knee or shoulder			Painful or severe menstrual periods		
Trick knee			Unusual vaginal discharge, pain, itching		
Fainting spells or unconsciousness			Date of last pelvic examination		
Convulsions or treatment for epilepsy			Was cancer smear taken?		
Paralysis or weakness of muscles			Number of pregnancies		
Shaking, tremors or trembling of hands			Number of miscarriages		

Habits

Do you smoke cigarettes? ☐ No ☐ Yes Cigars? ☐ No ☐ Yes Pipe? ☐ No ☐ Yes

If yes, how many cigarettes, cigars, pipefuls per day (average)?
Have you in the past? ☐ No ☐ Yes If yes, how many years did you smoke a pack+/day?
Do you drink coffee or caffeinated beverages? ☐ No ☐ Yes If yes, how many per day?
Do you take regular exercise? ☐ No ☐ Yes If yes, what type?
Number of alcoholic drinks per working day: On weekends?
Check any of the following if taken frequently:

☐ Aspirin, Anacin, Bufferin, etc. ☐ Weight reducers ☐ Allergy pills
☐ Sleeping pills ☐ Thyroid ☐ Prescription drugs
☐ Tranquilizers ☐ Iron ☐ Hormones
☐ Sedatives, nerve pills ☐ Tonics, vitamins ☐ Other
☐ Patent medications

Do you have allergies to medications?
Food? Other?

OCCUPATIONAL HISTORY

Total occupational history from your first job to your current position; list years employed

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Present job Years on this job:

Is there anything about your present job that concerns you? ☐ No ☐ Yes

☐ Fumes ☐ Dust ☐ Chemical ☐ Noise ☐Radiation ☐ X-ray ☐ Asbestos ☐Known toxic materials

Social and Educational History

	Grade/Junior High	High School	College	Graduate
Highest grade completed: (circle)	1 2 3 4 5 6 7 8	9 10 11 12	13 14 15 16	17 18 19 20

List major outside activities and hobbies:

Birthplace: Places of residence:

Recent travel outside California (last several years):

Were you ever in the Military Service (which service and when?):

Pets: Dogs Cats Birds Horses Sheep Other:

Family History (**include the ages and medical problems of relatives who have died**)

Member / Age	Medical Problems	Alive?
Father		
Mother		
Sisters		
Brothers		

Please check if any close relatives has had any of the following diseases:

☐ Asthma ☐ Heart trouble ☐ Kidney disease

☐ Hay Fever or allergies ☐ High blood pressure ☐Anemia/ blood disorder

☐ Cancer ☐ Mental or nervous disease ☐ Diabetes

☐ Epilepsy, convulsions ☐ Stroke ☐ Tuberculosis

Marital History

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Wife or Husband's age Present state of health

Number of children Ages: Present state of health

Number of dependents for whom you are responsible:

Any specific concerns or questions? ____________________