

HEALTH ASSESSMENT QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

Patient Address: _____

Phone: Home: _____ Cell: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Occupation: _____

EMAIL ADDRESS: _____ PRIMARY CARE PHYSICIAN: _____

PHARMACY NAME AND ADDRESS: _____

Reason for today's visit: _____

Is this **WORK RELATED**: Yes/ No **NAME AND ADDRESS OF EMPLOYER**: _____

AUTO OR PERSONAL Injury: Yes No **OTHER Injury**: Yes No

Description and Date of Injury: _____

Location of pain/problem: _____

Duration of Symptoms: _____

Past Treatment for this problem: _____

Please Check any Of The Following Medical Conditions That Apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> HA/VISION CHANGES | <input type="checkbox"/> MI / HEART ATTACK | <input type="checkbox"/> KIDNEY STONES |
| <input type="checkbox"/> GLAUCOMA/CATARACTS | <input type="checkbox"/> ARRYTHMIA | <input type="checkbox"/> URINARY TRACT INFECTION |
| <input type="checkbox"/> STROKE/TIA | <input type="checkbox"/> PEPTIC ULCER/REFLUX | <input type="checkbox"/> BLEEDING TENDENCY / COUMADIN |
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> INFLAMMATORY BOWEL DISEASE | <input type="checkbox"/> HISTORY OF BLOOD CLOT |
| <input type="checkbox"/> COPD | <input type="checkbox"/> HIATAL HERNIA | <input type="checkbox"/> ELEVATED CHOLESTEROL |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> POLYPS | <input type="checkbox"/> SEIZURE/CONVULSION |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> BOWEL/BLADDER INCONTINENCE |
| <input type="checkbox"/> CHEST PAIN / ANGINA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> FEVER / SWEATS / CHILLS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> FRACTURES |
| <input type="checkbox"/> GOUT | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> PSYCHIATRIC HISTORY |
| <input type="checkbox"/> TB | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HYPERTHYROIDISM | <input type="checkbox"/> HYPOTHYROIDISM |

Current Medications: _____

Past Surgeries: _____

Allergies to Medication: _____

Allergies to Latex: Yes No

Social History:

Marital Status: Single Married Divorced Widowed

Alcohol Use: Never Rarely Moderate Daily

Tobacco Use: Yes No # years: _____ # Packs/Day: _____ Do you currently smoke? Yes No

Drug Use: Never Name of Drug: _____ Frequency: _____

Family History: (Age, Diseases, If deceased cause of death)

Father: _____ Mother: _____

Siblings: _____

Children: _____

Spouse: _____