GREATER NEWPORT PHYSICIANS

HEALTH QUESTIONNAIRE AGES 18 – 64

Patient's Name:	Sex:	Date of Birth:
Address:	Phone:	

HISTORY OF PAST ILLNESS:
Have you ever had:

measles	☐ No ☐ Yes	rheumatic fever or heart disease	☐ No ☐ Yes
mumps	☐ No ☐ Yes	tuberculosis	☐ No ☐ Yes
chickenpox	☐ No ☐ Yes	a sexually transmitted disease	☐ No ☐ Yes
diabetes	☐ No ☐ Yes	congenital abnormalities	☐ No ☐ Yes
strokes	☐ No ☐ Yes	other serious diseases	☐ No ☐ Yes
cancer	☐ No ☐ Yes	(please specify):	

Have you ever:

been hospitalized:	☐ No ☐ Yes	had surgery:	☐ No ☐ Yes
(please specify):		(please specify):	

Have you ever:

		Do you have:	
had broken bones:	☐ No ☐ Yes	any allergies:	☐ No ☐ Yes
been knocked unconscious:	☐ No ☐ Yes	please specify(food, drugs, animals, etc.):	
had head concussions or injuries:	☐ No ☐ Yes		

FAMILY HISTORY:

	If Living		If Deceased	
	Age	Health	Age at death	Cause of death
Father				
Mother				
Brother / Sister				

Do you currently have, or have you ever had, any of the following:

General		**Neck**	
recent weight change?	☐ No ☐ Yes	stiffness?	☐ No ☐ Yes
Skin		thyroid trouble?	☐ No ☐ Yes
Jaundice?	☐ No ☐ Yes	enlarged glands?	☐ No ☐ Yes
Eczema, hives or rash?	☐ No ☐ Yes	**Respiratory**	
frequent infection or boils?	☐ No ☐ Yes	spitting up blood?	☐ No ☐ Yes
abnormal pigmentation?	☐ No ☐ Yes	chronic or frequent cough?	☐ No ☐ Yes
Head-Eyes-Nose-Throat		asthma?	☐ No ☐ Yes
eye disease or injury?	☐ No ☐ Yes	pleurisy or pneumonia?	☐ No ☐ Yes
glasses or contacts?	☐ No ☐ Yes	**Cardiovascular**	
double vision?	☐ No ☐ Yes	chest pain/heart attack?	☐ No ☐ Yes
headaches?	☐ No ☐ Yes	shortness of breath?	☐ No ☐ Yes
Glaucoma?	☐ No ☐ Yes	high blood pressure?	☐ No ☐ Yes
sneezing or runny nose?	☐ No ☐ Yes	swelling of hands/feet?	☐ No ☐ Yes
nose bleeds?	☐ No ☐ Yes	awakening in the night?	☐ No ☐ Yes
chronic sinus trouble?	☐ No ☐ Yes	heart murmur/palpitations?	☐ No ☐ Yes
ear disease?	☐ No ☐ Yes	**Gastrointestinal**	
impaired hearing?	☐ No ☐ Yes	peptic ulcer?	☐ No ☐ Yes
itching eyes or nose?	☐ No ☐ Yes	heartburn/indigestion?	☐ No ☐ Yes
unconsciousness?	☐ No ☐ Yes	vomiting blood?	☐ No ☐ Yes
dizziness?	☐ No ☐ Yes	gallbladder disease?	☐ No ☐ Yes
Genitourinary		liver trouble/hepatitis?	☐ No ☐ Yes
loss of urine?	☐ No ☐ Yes	painful/bloody bowel movements?	☐ No ☐ Yes
frequent urination?	☐ No ☐ Yes	hemorrhoids or black stools?	☐ No ☐ Yes
burning or painful urination?	☐ No ☐ Yes	change in bowel habits (diarrhea)?	☐ No ☐ Yes
blood in urine?	☐ No ☐ Yes	cramping / abdomen pain?	☐ No ☐ Yes
kidney trouble (stones)	☐ No ☐ Yes	food stuck in throat?	☐ No ☐ Yes
Musculoskeletal		**Neurologic**	
varicose veins?	☐ No ☐ Yes	fainting spells?	☐ No ☐ Yes
difficulty walking?	☐ No ☐ Yes	convulsions?	☐ No ☐ Yes
pain in calves or buttocks?	☐ No ☐ Yes	paralysis?	☐ No ☐ Yes
Endocrine	☐ No ☐ Yes	**Hematologic**	
thyroid disease?	☐ No ☐ Yes	slow to heal after cuts?	☐ No ☐ Yes
hormone therapy?	☐ No ☐ Yes	blood disease?	☐ No ☐ Yes
change in hat or glove size?	☐ No ☐ Yes	anemia?	☐ No ☐ Yes
feeling colder than before?	☐ No ☐ Yes	phlebitis?	☐ No ☐ Yes
dry skin?	☐ No ☐ Yes	excessive bleeding?	☐ No ☐ Yes
Psychiatry		abnormal bruising?	☐ No ☐ Yes
advised to seek treatment for:		**Immunizations / Tests**	
depression?	☐ No ☐ Yes	Tetanus / Diptheria (dT)?	☐ No ☐ Yes
anxiety and/or panic	☐ No ☐ Yes	If yes, when?	
severe stress?	☐ No ☐ Yes	blood cholesterol measurement?	☐ No ☐ Yes
alcohol and/or drug abuse?	☐ No ☐ Yes	If yes, when?	
addiction to cigarettes?	☐ No ☐ Yes	Colorectal Cancer Screening?	☐ No ☐ Yes
		If yes, when?	

Gyneclolgical (Females only)

At what age did your menstrual cycle begin:	Date of last period:
Frequency of periods (# of days in between):	Number of pregnancies:
Average # of days each period lasts:	Number of miscarriages / abortions:
Pain during intercourse? ☐ No ☐ Yes	Low sex drive? ☐ No ☐ Yes
Date of last PAP test: Normal? ☐ No ☐ Yes	Date of last mammo: Normal? ☐ No ☐ Yes

Signature of Patient or Guardian:	Date:
Name (please print):	Relationship to Patient: