# Hess Clinic Health Questionnaire

**Name:** _____ **Date of Birth:** _____ **Today's Date:** _____
**Address:** _____ **City:** _____ **State:** _____
**Home Phone #:** _____ **Work Phone #:** _____ **Cell/Other #:** _____
**Date of Last: Doctor Visit**_____ **Dental Visit**_____ **Eye Exam**_____
**Name of Last: Physician** _____ **Dentist** _____ **Eye Doctor**_____
**Do you see any other physicians? No**____ **Yes**_____
**What is the reason for today's visit?** _____
**How did you hear about us?** _____

**Medical History – Mark (C) for CURRENT problems. Mark (P) for PAST problems now resolved.**

__ Decreased Hearing
__ Ringing in ears
__ Ear Infections
__ Dizzy Spells
__ Fainting
__ Failing Vision
__ Blurred Vision
__ Nose Bleeds
__ Sinus Trouble
__ Sore Throats
- Frequent
__ Hoarseness
– prolonged
__ Hay fever/Allergies
__ Pneumonia/Pleurisy
__ Bronchitis/ Chronic
__ Cough
__ Asthma / Wheezing
__ Shortness of Breath
_ on exertion _ lying down
_ recent _ affects work
__ Chest Pain
__ High Blood Pressure
__ Heart Murmur
__ Edema
__ Irreg. Pulse
__ Palpitations
__ Cervical Dysplasia
__ Varicose Veins

__ Loss of Appetite
-- recent
__ Difficulty Swallowing
__ Heartburn
__ Peptic Ulcer
__ Nausea / Vomiting
__ Gallbladder Problems
__ Jaundice / Hepatitis
__ Irritable Bowel Syndrome
__ Abdominal Pain
__ Bloating / Discomfort
__ Diarrhea
__ Constipation
__ Inflammatory Bowel
__ Diverticulitis
__ Crohn's __ Colitis
__ Bloody or Tarry Stools
__ Hemorrhoids
__ Hernia
__ Overactive Bladder
__ Painful Urination
__ Urine Infections
__ Urinary Frequency
__ Bed Wetting
__ Weight Loss /Gain
__ Anemia
__ Bruise Easily
__ Blood Transfusions
__ Fatigue
__ Headaches
__ ADD/ADHD

__ Cold Numb Feet
__ Thyroid Disease
__ Seizures
__ Stroke
__ Tremors
__ Numbness
__ Arthritis
__ Bone Fracture
__ Joint Injury
__ Osteoporosis
__ Back Pain
__ Foot Pain __ Gout
__ Rashes __ Hives
__ Psoriasis
__ Eczema
__ Concentration Probs
__ Depression
__ Anxiety
__ Memory Loss
__ Suicidal Thoughts
__ Phobias
__ Mental Illness
__ Sleep Problems
__ Sexual Problems
__ Excess Facial Hair
__ Hair Loss
__ Decreased Endurance
__ Leg Pain
- when walking
__ Diabetes
__ Coronary Artery Disease

Vaccines

__ Tetanus _____
__ Influenza _____
__ Pneumonia _____
__ Hepatitis A _____
__ Hepatitis B _____
__ Pertussis _____
__ MMR _____
__ Tdap _____
__ Meningitis _____
__ Varicella _____
__ HPV _____

Female Exams
Date of Last:
Pap Test _____
Mammogram _____
Pregnancies (#) _____

Male Exams
Date of Last:
Prostate Exam _____

Date of Last
M & F
Rectal Exam _____
Cholesterol _____
Hemoccult _____

Notes: _____

**Provider Signature:** _____ **Date Reviewed:** _____

**FAMILY HISTORY – If Any BLOOD Relative has any of the following- Please Circle and indicate which relative.**

| | | | |
|---|---|---|---|
| 1) Epilepsy | 6) Thyroid | 11) Osteoporosis | 16) High Cholesterol |
| 2) Migraine | 7) Depression | 12) Arthritis | 17) Alcoholism |
| 3) Mental Illness | 8) Asthma | 13) Heart Disease | 18) Obesity |
| 4) Glaucoma | 9) Anemia | 14) Stroke | 19) Cancer |
| 5) Diabetes | 10) Bleeds Easily | 15) High Blood Pressure | |

| **HOSPITAL ADMISSIONS** | **Year** | **Illness or Operation** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| **MEDICATIONS- List ALL Those Currently Taking** | | **MEDICATION ALLERGIES** |
|---|---|---|
| | | |
| | | |
| | | |
| | | **SUPPLEMENTS** |
| | | |
| **PHARMACY:** | | |

**SOCIAL HISTORY:**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Ethnicity/Race: ☐ Caucasian ☐ Asian ☐ African American ☐ Hispanic Other: _____

Preferred language: ☐ English ☐ Spanish Other: _____

Do you currently smoke or have you ever smoked in the past? ☐ No ☐ Yes, #pack per day _____

Start Date: _____ Quit Date: _____

Do you use alcohol? ☐ No ☐ Rarely ☐ Socially ☐ Moderately ☐ Daily, # drinks per day _____

Have you ever used illegal drugs? ☐ No ☐ Yes Do you wear a seat belt? ☐ No ☐ Yes

What is your occupation? _____

Are you exposed to hazards? ___ No ___ Yes If Yes, what? _____

**Notes:** _____

**PATIENT SIGNATURE:** _____ **DATE:** _____