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
__ Bet 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		**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: _____