



General Health Questionnaire

Name: \_\_\_\_\_

Doctor: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Chief Complaint: List the medical problem(s) which lead you to seek medical help now, and when each problem began.

Major Health Problems: \_\_\_\_\_

1. General Health

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Handedness: Left \_\_\_ Right \_\_\_

Are you generally healthy? Y \_\_\_ N \_\_\_

If not, why? \_\_\_\_\_

Have you had:

Cancer, tumor, leukemia: Y \_\_\_ N \_\_\_

Other serious illness: Y \_\_\_ N \_\_\_

If so, what? \_\_\_\_\_

2. Operations:

Have you had any operations? Y \_\_\_ N \_\_\_

If so, list all previous operations/date of surgery

\_\_\_\_\_

Any surgical complications? Y \_\_\_ N \_\_\_

If so, explain: \_\_\_\_\_

\_\_\_\_\_

3. Medication:

Please list all current medications and their doses:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Diabetes, pills or insulin shots? \_\_\_\_\_

High blood pressure, pills or shots? \_\_\_\_\_

Diuretics, water pills or shots? \_\_\_\_\_

Heart medicines, including nitroglycerin? \_\_\_\_\_

Blood thinner pills – Coumadin? \_\_\_\_\_

Antibiotics? \_\_\_\_\_

Pain pills, including aspirin? \_\_\_\_\_

4. Allergies: (List all drug allergies)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. System Reviews:

Skin – Have you had:

Skin infections or boils? \_\_\_\_\_

Sores that do not heal? \_\_\_\_\_

Change in skin moles? \_\_\_\_\_

Head – have you had:

Recent severe headaches? \_\_\_\_\_

Blackouts or fainting spells? \_\_\_\_\_

Convulsions or epilepsy? \_\_\_\_\_

Eye, Ear, Nose & Throat – had you had:

Glaucoma? \_\_\_\_\_

Ear Infections? \_\_\_\_\_

Trouble with balance? \_\_\_\_\_

Difficulty or pain with swallowing? \_\_\_\_\_

Breast: (Both men and women please answer)

Do you have a lump or tumor now? \_\_\_\_\_

Have you had a discharge from a nipple? \_\_\_\_\_

Heart & Lungs:

Does shortness of breath limit activity? \_\_\_\_\_

Do you prop yourself up to sleep? \_\_\_\_\_

Have you had:

Frequent cough? \_\_\_\_\_

Emphysema? \_\_\_\_\_

Chest pain or discomfort? \_\_\_\_\_

Leg cramps at night? \_\_\_\_\_

Leg aches when walking? \_\_\_\_\_

Tuberculosis? \_\_\_\_\_

Pneumonia? \_\_\_\_\_

Coughing up blood? \_\_\_\_\_

A heart attack or coronary problems? \_\_\_\_\_

Angina? \_\_\_\_\_

Blood clots? \_\_\_\_\_

An abnormal electrocardiogram? \_\_\_\_\_  
Heart murmur? \_\_\_\_\_  
High blood pressure? \_\_\_\_\_  
Varicose veins? \_\_\_\_\_  
Swollen ankles? \_\_\_\_\_  
Inflamed veins? \_\_\_\_\_

Stomach & Bowels – Have you had:

Pain, indigestion or heartburn? \_\_\_\_\_  
Cramps in the stomach or abdomen? \_\_\_\_\_  
Bloody or black bowel movements? \_\_\_\_\_  
Are you taking Iron? \_\_\_\_\_  
Frequent loose stool or diarrhea? \_\_\_\_\_  
Recent changes in bowel habits? \_\_\_\_\_  
Stomach, duodenal or peptic ulcer? \_\_\_\_\_  
Hepatitis or cirrhosis? \_\_\_\_\_  
Gall bladder disease or pancreatitis? \_\_\_\_\_

Kidney & Bladder:

Do you often get up to urinate? \_\_\_\_\_  
Has urination been painful recently? \_\_\_\_\_  
Do you lose control of your bladder? \_\_\_\_\_

Glands – have you had?

Diabetes? \_\_\_\_\_  
Sugar in urine or blood? \_\_\_\_\_  
A thyroid disorder? \_\_\_\_\_  
Other glandular problems? \_\_\_\_\_

Blood – have you had?

Swollen glands in armpits, neck and groin? \_\_\_\_\_  
Excessive bleeding with operations? \_\_\_\_\_  
A diagnosis of “bleeder”? \_\_\_\_\_  
A diagnosis of anemia, past or present? \_\_\_\_\_

6. Family History: have any of your blood relatives, including children had:

Diabetes? \_\_\_\_\_  
Cancer, leukemia, or Hodgkin’s Disease? \_\_\_\_\_  
Heart problems? \_\_\_\_\_  
A stroke? \_\_\_\_\_  
Anemia or bleeding tendency? \_\_\_\_\_  
Kidney trouble or Bright’s disease? \_\_\_\_\_  
Any disease that runs in the family? \_\_\_\_\_

7. Personal and Social History:

Are you married \_\_ single \_\_ widowed \_\_ divorced? \_\_  
Have any of your children had birth defects? \_\_\_\_\_  
Do you get regular exercise? \_\_\_\_\_  
What is your occupation? \_\_\_\_\_  
Are you currently employed? \_\_\_\_\_  
If not, when did you last work? \_\_\_\_\_  
Are you disabled? \_\_\_\_\_  
List any hobbies that require special physical skills:  
\_\_\_\_\_  
\_\_\_\_\_

Are you retired? \_\_\_\_\_

Do you drink alcohol regularly? \_\_\_\_\_  
Do you have more than 3 drinks a day? \_\_\_\_\_  
Are you a smoker? \_\_\_\_\_  
How much do you smoke a day? \_\_\_\_\_  
Have you smoked within the last 6 months? \_\_\_\_\_

DO YOU HAVE ANY OTHER PROBLEMS THAT HAVE NOT BEEN MENTIONED?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all current treating physicians:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOR OFFICE USE ONLY**

X-Ray Requested:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician Signature