

General Health Questionnaire

A Ten Minute Survey of Your Health

Name: _____

Today's Date: _____

Date of Birth: _____



What are the health concerns that brought you to see the doctor? _____

	<u>Yes</u>	<u>No</u>
General	_____	_____
1. Have you gained more than ten pounds in the past six months? Have you lost more than ten pounds in the past six months?	_____	_____
2. Do you have fever or sweat at night?	_____	_____
3. Have you had the Flu Vaccine? If Yes, When? _____	_____	_____
4. Have you had the Pneumonia Vaccine? If Yes, When? _____	_____	_____
Skin	_____	_____
5. Have you had a change in a mole on your skin in the past year?	_____	_____
6. Do you have itchy skin or a rash most of the time?	_____	_____
Head	_____	_____
7. Do you have frequent, severe, or sick headaches?	_____	_____
8. Have you had any recent scalp problems such as itching, hair loss, or sores?	_____	_____
Eyes	_____	_____
9. In the past year, has there been any change in your vision?	_____	_____
10. Has a doctor said you have glaucoma?	_____	_____
11. Do you have pain within the eyes?	_____	_____
12. Have you ever had short spells of blindness?	_____	_____
13. Do you see an eye doctor regularly?	_____	_____
Ears	_____	_____
14. Have you had a hearing loss in the last six months that is still present?	_____	_____
15. Do you have buzzing or ringing in the ears?	_____	_____
Nose	_____	_____
16. Is your nose running almost every day?	_____	_____
17. Do you have hay fever?	_____	_____
18. Have you ever taken allergy shots?	_____	_____
19. Have you ever been told you had polyps (small growths) in your nose?	_____	_____
20. Do you have problems with a bloody nose?	_____	_____
Mouth/Throat	_____	_____
21. Do you have bleeding gums?	_____	_____
22. Have you developed a hoarse voice which has not improved?	_____	_____
23. Have you ever had radiation treatments or x-ray treatments to your head or neck?	_____	_____

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- 54. Do you have to get up from sleep to urinate (pass your water)?
55. Do you have any burning or pain when urinating (passing water)?
56. Do you ever leak urine?
57. Have you ever passed bloody or dark brown urine the color of coffee?
58. Have you ever had a kidney or bladder infection?
59. Have you ever had a sexually transmitted disease?
60. Have you ever had kidney stones?

Men Only

- 61. Do you have a slow or small stream when urinating (passing water)?
62. Have you had any discharge from the penis?
63. Have you ever had an infection of your prostate gland?

Women Only

- 64. Have you had a heavy discharge from the vagina in the past six months?
65. Are you bothered by itching or dryness in the vaginal area?
66. Are you still having menstrual periods?
67. If you are still having menstrual periods, have you had any bleeding between periods or very heavy or long bleeding with your periods?
68. If you have stopped menstruating, have you had any bleeding or spotting?
69. Have you had any discharge from your breast nipples in the past year (do not answer "yes" if you are nursing or pregnant)?
70. Do you check your breasts on a monthly basis?
71. Have you ever had a mammogram? If yes, when was the most recent mammogram?
72. Have you discovered any breast lumps in the past year?
73. Have you ever had an abnormal PAP smear?

Bone and Joint

- 74. Has a doctor told you that you had gout?
75. When your fingers get cold, do they become numb, hurt, or change colors?
76. Have you had any arthritis or rheumatism of the joint?
77. Do you have back pain that is so bad that you are unable to do your regular work?
78. Have you had any stiffness in your joints that lasted more than thirty minutes?

Metabolism

- 79. Has a doctor told you that you have diabetes (sugar)?
80. Has a doctor told you that you have thyroid disease or a goiter?
81. Have you ever been told you have elevated or high blood cholesterol or blood lipids?

Blood

- 82. Has a doctor told you that you have anemia (low blood count)?
83. Have you had any large glands or swelling in the neck, armpits, or groin in the past year?
84. Has a doctor ever said you have cancer or a tumor?
85. Have you ever had problems with excessive bleeding?
86. Have you ever had a blood transfusion?

Neuro

- 87. Have you ever lost consciousness (been knocked out) or fainted? _____
- 88. Have you ever had epilepsy or seizures? _____
- 89. Has a doctor ever told you that you had a stroke? _____
- 90. Do you have numbness or weakness in an arm or leg? _____
- 91. Do you think you are experiencing problems with your memory? _____

Habits/Health Maintenance

- 92. Have you ever smoked cigarettes?
If yes, how many packs per day? _____. How many years have you smoked? _____
- 93. Do you believe you might have a drinking problem? _____
- 94. Have you ever decided to cut down on your drinking? _____
- 95. How many cups of caffeinated coffee, tea, or colas do you drink each day? _____
- 96. Do you follow any special diet? If so, what? _____
- 97. Do you exercise two or more times per week? _____
- 98. Did you have basic immunization shots for tetanus, diphtheria, and polio?
Not sure _____
- 99. When was your last tetanus booster? _____
- 100. Have you had any occupational (or recreational) exposure to chemicals or toxins? _____

Social/Emotional

- 101. Do you have problems sleeping? _____
- 102. Do you suffer from anxiety or nervousness? _____
- 103. Do you have any concerns about your sexual life? _____
- 104. Do you worry that you might have been exposed to AIDS? _____

Activities of Daily Living

Do you have any trouble with any of the following:

- Hearing? _____ Driving? _____ Dressing/Bathing? _____
- Seeing? _____ Fixing Meals? _____ Rising out a chair? _____

Advance Directives

Are you interested in learning about advance directives regarding your health care? (This is a written document in which you specify what type of medical care you want if in the future, you lose the ability to make that decision).

Yes, I am interested _____ No, I am not interested at this time _____

Family History

Has anyone in your immediate family ever been diagnosed with:

Heart Attack? Yes ___ No ___ If yes, which family member? _____
At what age? _____

Heart Disease? Yes ___ No ___ If yes, which family member? _____

Stroke? Yes ___ No ___ If yes, which family member? _____

Diabetes? Yes ___ No ___ If yes, which family member? _____

High Blood Pressure? Yes ___ No ___ If yes, which family member? _____

Yes

No

Cancer? Yes ___ No ___ If yes, which family member? _____
What type? _____

Past Medical History

Have you been hospitalized for any reason in the past five years?

If yes, for what reason? _____ Date: _____

Have you had any surgeries in the past five years?

If yes, for what reason? _____ Date: _____

Are you currently taking any medications?

If yes, please list them below:

Please describe any other health problems that you are currently experiencing: _____

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____