THE ELKHART CLINIC HEALTH QUESTIONNAIRE DEPT OF INTERNAL MEDICINE

**** PLEASE FILL OUT AND BRING WITH YOU ON THE DAY OF YOUR APPOINTMENT ALONG WITH YOUR MEDICINES ****

Name: Sex: F M DOB: Age: Date:

Home Phone: Work: Cell: email: Originally Referred by:

PAST MEDICAL HISTORY: OCCUPATION: **Medical Alert:** □ Yes □ No

Mark any diseases that you have had:

□ Anemia	□ Depression	□ Irritable Bowel	□ Sinus Problems
□ Angina	□ Diabetes Type I	□ Kidney Infection	□ Sleep Apnea
□ Asthma	□ Diabetes Type II	□ Malaria	□ Sleep Disorder
□ Bleeding Tendencies	□ Diphtheria	□ Measles	□ Snoring
□ Blood Clots	□ Emphysema	□ Mumps	□ Stroke
□ Cancer	□ Hay Fever	□ Nervous Breakdown	□ STD
□ Chicken Pox	□ Hives	□ Osteoarthritis	□ Ulcer
□ Collagen Vascular Disease	□ High Blood Pressure	□ Osteoporosis	□ Whooping Cough
□ Convulsions	□ High Cholesterol	□ Pleurisy	**Other:**
□ Dementia	□ Irregular heart beat	□ Pneumonia	
		□ Rheumatic Fever	

List any other diseases, surgeries, serious injuries or hospitalization you have had and their dates:

□ **NO PREVIOUS ILLNESS OR SURGERY**

Date of last: Diptheria________Influenza________ Pneumovax________Polio________Tetanus________Zostavax________

Family Hx	**Age**	**State of Health**	**If deceased, cause**	***List any BLOOD relatives with the following diseases.***	
Father				Anemia or Blood clots	Osteoporosis
Mother				Arthritis	Snoring/Sleep Apnea
Siblings				Asthma	Stroke
				Cancer	Thyroid Disorder
				Diabetes	Ulcer
				Epilepsy/Seizures	
				Hay fever	
Spouse				Heart Trouble	
Children				High blood pressure	
				Kidney disease	
				Mental Illness/Depression	

PATIENT SOCIAL HISTORY (check off):

Marital Status:	□ Single	□ Married	□ Divorced: How long?	□ Widowed: How long?	
Use of Alcohol:	□ Never	□ Rarely	□ Moderate	□ Daily	**Define Quantity** ________________
Use of Coffee:	□ Regular Cups/Day__________		□ Decaff Cups/Day__________		
Use of Tobacco:	□ Never	□ Previously, But quit-year__________	Packs/day______	Pack years ________(lifetime)	
Use of Drugs:	□ Never	□ Marijuana	□ Crack/Cocaine	□ Heroin	□ Amphetamine
Use of Seatbelt:	□ Rarely	□ Sometimes	□ Always		
Excessive Exposure at home/w	□ Fumes	□ Dust	□ Solvents	□ Airborne Particles	□ Noise
Exercise:	□ Walking	□ Bicycling	□ Running	Other: ______________ No. of days/week______	No. of minutes ________

MEDICATIONS: (list additional on separate page)		**ALLERGIES:**
1.	5.	1.
2.	6.	2.
3.	7.	3.
4.	8.	4.

ALTERNATIVE MEDICINES/VITAMINS/OTC MEDICATION:

1.	3.
2.	4.

PATIENT SIGNATURE________________________________Reviewed by: Physician Signature______________________ (see next page)

Patient Name: **DOB:** **Date:**

General	Fever/chills/sweats	☐ No	☐ Yes
	Anorexia/Fatigue	☐ No	☐ Yes
	Weakness/malaise/headache	☐ No	☐ Yes
	Recent weight loss/weight gain	☐ No	☐ Yes
Eyes	Halos	☐ No	☐ Yes
	Vision loss	☐ No	☐ Yes
	Double vision	☐ No	☐ Yes
	Eye irritation	☐ No	☐ Yes
	Blurring	☐ No	☐ Yes
	Eye Pain	☐ No	☐ Yes
	Discharge	☐ No	☐ Yes
	Light sensitivity	☐ No	☐ Yes
ENT	Ringing in ears	☐ No	☐ Yes
	Ear discharge	☐ No	☐ Yes
	Earache	☐ No	☐ Yes
	Hearing loss	☐ No	☐ Yes
	Nasal congestion	☐ No	☐ Yes
	Difficulty swallowing	☐ No	☐ Yes
	Hoarseness/Sore throat	☐ No	☐ Yes
	Bad breath or bad taste	☐ No	☐ Yes
	Voice change	☐ No	☐ Yes
	Mouth sores	☐ No	☐ Yes
	Bleeding/swollen gums	☐ No	☐ Yes
	Poor teeth	☐ No	☐ Yes
CV	Chest pain,pressure,tightness, discomfort	☐ No	☐ Yes
	Rapid/Irregular heartbeat	☐ No	☐ Yes
	Palpitations	☐ No	☐ Yes
	Lightheadedness	☐ No	☐ Yes
	Swelling of feet	☐ No	☐ Yes
	Bluish discoloration of lips/nails	☐ No	☐ Yes
Resp	Shortness of breath at rest	☐ No	☐ Yes
	Shortness of breath with exertion	☐ No	☐ Yes
	Awake at night with shortness of breath	☐ No	☐ Yes
	Cough	☐ No	☐ Yes
	Coughing up blood	☐ No	☐ Yes
	Wheezing	☐ No	☐ Yes
	Asthma	☐ No	☐ Yes
	Sputum production	☐ No	☐ Yes
GI	Loss of appetite/excessive appetite	☐ No	☐ Yes
	Indigestion/heartburn	☐ No	☐ Yes
	Excessive gas	☐ No	☐ Yes
	Abdominal bloating	☐ No	☐ Yes
	Abdominal pain	☐ No	☐ Yes
	Yellowish skin color	☐ No	☐ Yes
	Nausea/vomiting	☐ No	☐ Yes
	Vomiting blood	☐ No	☐ Yes
	Diarrhea	☐ No	☐ Yes
	Partial bowel movements or constipation	☐ No	☐ Yes
	change in bowel habits	☐ No	☐ Yes
	Dark tarry/bloody stools	☐ No	☐ Yes
	Hemorrhoids	☐ No	☐ Yes
	Rectal bleeding	☐ No	☐ Yes
GU	Painful urination	☐ No	☐ Yes
	Blood in urine	☐ No	☐ Yes
	Discharge	☐ No	☐ Yes
	Urinary frequency	☐ No	☐ Yes
	Urinary hesitancy	☐ No	☐ Yes
	Frequent nighttime urination	☐ No	☐ Yes
	Urinary dribbling	☐ No	☐ Yes
	Change in force of stream when urinating	☐ No	☐ Yes
	Genital sores	☐ No	☐ Yes
	Decreased sexual desire	☐ No	☐ Yes
	Sexual dystunction	☐ No	☐ Yes
	Male - Erectile dysfunction or impotence	☐ No	☐ Yes
	Female-Breast pain, lump or discharge	☐ No	☐ Yes
	Female-pain w/periods or irregular periods	☐ No	☐ Yes
	No. of pregnancies________# of miscarriages_______		
	Age of first period________Age of first pregnancy_______		
	Female-date of last period________________________		

MS	Muscle cramps	☐ No	☐ Yes
	Muscle weakness	☐ No	☐ Yes
	Leg cramps with exertion	☐ No	☐ Yes
	Muscle aches	☐ No	☐ Yes
	Difficulty walking	☐ No	☐ Yes
	Joint pain	☐ No	☐ Yes
	Joint stiffness	☐ No	☐ Yes
	Joint swelling	☐ No	☐ Yes
	Back pain	☐ No	☐ Yes
	Cold extremeties	☐ No	☐ Yes
Skin	Excessive sweating	☐ No	☐ Yes
	Skin dryness	☐ No	☐ Yes
	Skin flushing	☐ No	☐ Yes
	Change in skin color	☐ No	☐ Yes
	Changes in mole	☐ No	☐ Yes
	Changes in suspicious lesion	☐ No	☐ Yes
	Skin rash	☐ No	☐ Yes
	Change in hair or nails	☐ No	☐ Yes
	Unusual hair distribution	☐ No	☐ Yes
	Varicose veins	☐ No	☐ Yes
Neuro	Frequent headaches	☐ No	☐ Yes
	Convulsions	☐ No	☐ Yes
	Tremors	☐ No	☐ Yes
	Fainting	☐ No	☐ Yes
	Difficulty concentrating	☐ No	☐ Yes
	Confusion/Memory loss	☐ No	☐ Yes
	Lightheadedness/Dizziness	☐ No	☐ Yes
	Spells/Poor balance	☐ No	☐ Yes
	Falling down	☐ No	☐ Yes
	Sensation of room spinning	☐ No	☐ Yes
	Brief paralysis/Unable to speak	☐ No	☐ Yes
	Disturbances in coordination	☐ No	☐ Yes
	Numbness/Tingling	☐ No	☐ Yes
	Excessive daytime sleepiness	☐ No	☐ Yes
	Snoring	☐ No	☐ Yes
Psych	Anxiety/ nervousness	☐ No	☐ Yes
	Irritability	☐ No	☐ Yes
	Depression	☐ No	☐ Yes
	Insomnia	☐ No	☐ Yes
	Hallucinations/delusions	☐ No	☐ Yes
	Frightening sounds	☐ No	☐ Yes
	Sense of great danger	☐ No	☐ Yes
	Thoughts of suicide/violence/homicide	☐ No	☐ Yes
Endo	Intolerance to heat or cold	☐ No	☐ Yes
	Excessive hunger/thirst	☐ No	☐ Yes
	Excessive urination	☐ No	☐ Yes
	Glandular changes	☐ No	☐ Yes
	Night sweats	☐ No	☐ Yes
	Changes in hat or glove size	☐ No	☐ Yes
Blood	Abnormal bruising	☐ No	☐ Yes
	Skin discoloration	☐ No	☐ Yes
	Bleeding tendancies	☐ No	☐ Yes
	Enlarged lymph nodes	☐ No	☐ Yes
	Slow healing	☐ No	☐ Yes
Allergy	Allergies	☐ No	☐ Yes
	Rash/hives	☐ No	☐ Yes
	Anaphylaxis	☐ No	☐ Yes

Additional Comments: Remember, This is YOUR health

Preventative Health Screening: (date of most recent)

Physical Exam ____________ Dexa Scan______________

Opthalmology Exam__________ Stress test ____________

Chest x-ray ______________ EKG___________________

Sigmoidoscopy/Colonoscopy ______________________

Mammogram: ________________Pap smear___________

Patient Signature_______________________________________ **Physician Signature**_______________________________