

Family Health Care of Post Falls
 1110 Polston Ave., Suite 1 Post Falls, ID 83854
 Phone (208) 773-1311 Fax (208) 773-1644

HEALTH QUESTIONNAIRE

Name _____ Date _____

If any blood relative has suffered any of the following please circle the number & indicate relative

- | | | | | |
|------------------|------------|------------------|---------------------|------------------|
| 1 Epilepsy | 5 Thyroid | 9 Osteoporosis | 13 High Cholesterol | 17 Bleeds easily |
| 2 Migraine | 6 Hayfever | 10 Arthritis | 14 Alcoholism | 18 Hypertension |
| 3 Mental Illness | 7 Asthma | 11 Heart disease | 15 Cancer | |
| 4 Glaucoma | 8 Anemia | 12 Stroke | 16 Diabetes | |

HOSPITAL ADMIN (not including pregnancies)	YEAR	ILLNESS/OPERATION	YEAR	ILLNESS/OPERATION

List all medications you are currently taking Include those you buy without a prescription	ALLERGIES	VACCINE	Year of Last	TEST/EXAM	Year of Last
_____	_____	Tetanus/TD	_____	Rectal/stool	_____
_____	_____	Influenza/flu	_____	Cholesterol	_____
_____	_____	Pneumonia	_____	Eye	_____
_____	_____	Hepatitis	_____		_____
_____	_____	Tuberculosis	_____		_____

Mark (C) for current problems – check & indicate age when you had any of the following symptoms or diseases

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Heartburn <input type="checkbox"/> peptic ulcer | <input type="checkbox"/> Numbness/tingling sensation | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Ringing in ear | <input type="checkbox"/> Persistent nausea/vomiting | <input type="checkbox"/> Headaches – frequent | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Ear infections – frequent | <input type="checkbox"/> Abdominal pain – chronic | <input type="checkbox"/> Arthritis/rheumatism | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Dizzy/fainting spells | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Back pain - recurrent | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Failing vision <input type="checkbox"/> Eye pain | <input type="checkbox"/> Jaundice/hepatitis | <input type="checkbox"/> Bone fracture/joint injury | Males |
| <input type="checkbox"/> Double or blurred vision | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Gout | Prostate PSA Test _____ |
| <input type="checkbox"/> Eye infections – frequent | <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation | <input type="checkbox"/> Foot pain <input type="checkbox"/> Cold/Numb | Females |
| <input type="checkbox"/> Nose bleeds – recurrent | <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's Colitis | <input type="checkbox"/> Rashes <input type="checkbox"/> Hives | Menstrual Flow |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Bloody or tarry stools | <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema | <input type="checkbox"/> Reg <input type="checkbox"/> Irreg <input type="checkbox"/> Pain |
| <input type="checkbox"/> Sore throats – frequent | <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia | <input type="checkbox"/> Sleeping – difficulty | Days of Flow ___ Lgth of Cycle ___ |
| <input type="checkbox"/> Hayfever/allergies | <input type="checkbox"/> Urine infections – frequent | <input type="checkbox"/> Depression <input type="checkbox"/> Nervousness | 1 st day of last period _____ |
| <input type="checkbox"/> Hoarseness – prolonged | <input type="checkbox"/> Blood in urine <input type="checkbox"/> kidney stones | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Pain/bleeding during/after sex _____ |
| <input type="checkbox"/> Pneumonia/pleurisy | Urination <input type="checkbox"/> overnight > 2 | <input type="checkbox"/> Moodiness – excessive | Pregnancies _____ |
| <input type="checkbox"/> Bronchitis/chronic cough | <input type="checkbox"/> Painful <input type="checkbox"/> Loss of control | <input type="checkbox"/> Mental Illness <input type="checkbox"/> Phobias | Abortions _____ |
| <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Decrease in force/flow | <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever | Miscarriages _____ |
| <input type="checkbox"/> Shortness of breath on exertion | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Chicken pox <input type="checkbox"/> Polio | Live births _____ |
| <input type="checkbox"/> Shortness of breath on lying flat | <input type="checkbox"/> Urethral discharge | <input type="checkbox"/> Mumps | Birth Control Method _____ |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Measles <input type="checkbox"/> German measles | B.C. Pill (name) _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Weight loss – recent | <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes | <input type="checkbox"/> Flushing/menopause |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Anemia <input type="checkbox"/> +ruise easily | <input type="checkbox"/> Alcohol ___ oz. per week | Date of last PAP Test _____ |
| <input type="checkbox"/> Irreg pulse <input type="checkbox"/> palpitations | <input type="checkbox"/> Cancer | <input type="checkbox"/> Smoking ___ cig/day ___# of years/year quit _____ | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> Leg pain – when walking | <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Coffee/tea ___ cups per day | Date of last mammogram _____ |
| <input type="checkbox"/> Varicose veins/Phlebitis | <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke | <input type="checkbox"/> Regular exercise | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> Loss of appetite - recent | <input type="checkbox"/> Tremor/hands shaking | | |