One Care Medical
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Health Questionnaire

In order for your physician to more completely assess your present health condition, please complete this individual health questionnaire as carefully as possible and bring with you for your appointment. If more space is required, please attach separate sheet.

General Information

Name: _____ Date _____

Reason for appointment: _____

_____

Previous Medical History (please include dates, names of doctors / hospitals, type of treatments)

Medical Illnesses: _____

_____

_____

_____

_____

Hospitalizations: _____

_____

_____

_____

Previous Surgeries: _____

_____

_____

_____

Transfusions / Exposures to Blood Products: _____

_____

Health History (please circle any of the conditions you have had in the past)

Hay Fever	Emotional Problems	Liver Disease	Rheumatic Fever
Abnormal Pap	Arthritis	Thyroid Trouble	Heart Attack
Asthma	Uncontrolled Bleeding	Cholesterol Problem	Emphysema
Alcoholism	High Blood Pressure	Weight Problem	Sexually Transmitted Disease
Cancer	Jaundice	Pleurisy	Pneumonia
Heart Murmur	Sugar Diabetes	Radiation Treatment	Hepatitis
Kidney Disease	Tuberculosis (TB)	Colon Polyps	Congestive Heart Failure

Review of Examinations / Immunizations (indicate the year in which you last had any of the following)

Female: Pap Smear: _____ Mammogram: _____

Male: Prostate Exam: _____

Flu Vaccine: _____ Tetanus Shot: _____ Hepatitis Vaccine: _____

Pneumonia Shot: _____ T.B. Test: _____ Pulmonary Function: _____

Cholesterol Test: _____ EKG: _____ Stress Test: _____

Dental Exam: _____ Eye Exam: _____ Bone Density Test: _____

Sigmoid/Colonoscopy: _____ Stool Blood Test: _____ Rectal Exam: _____

Alcohol, Drug, and Tobacco History

Cigarettes/Cigar/Pipe: Amount per week _____ Per Day _____

Smokeless Tobacco (chew): Amount per week _____ Per Day _____

Age at onset: _____ Quit? _____ Year Quit: _____

How would you describe your use of alcohol? _____

Amount per week: beer _____ wine _____ liquor _____

Use of recreational and intravenous drugs: Yes _____ No _____

Have you ever attended or felt you should attend a drug or alcohol rehabilitation program? _____

If yes, please explain: _____

_____

Review of Symptoms (please circle all symptoms you have experienced recently)

General

Fatigue Weight Loss Change in weight Excessive Sleepiness Change in appetite
Change in sleep Hair Loss Dry mouth Sweating Sensitive to Sunlight
Night sweats Bruising Insomnia Shakiness Snoring Bleeding

Gastrointestinal

Constipation Nausea Abdominal pain Abdominal distention Blood in stool
Jaundice Vomiting Vomiting blood Difficulty swallowing Painful swallowing
Diarrhea Heartburn Hepatitis/Liver Problems Black stool Hemorrhoids

Cardiovascular

Chest pain Palpitations Anemia Heart attack High blood pressure
Fainting Blood clots Ankle swelling Heart Murmur Leg cramps with walking

Respiratory

Cough Wheezing Coughing up blood Shortness of breath Chest pain on inspiration

Endocrine / Glands

Excessive hair growth Change in libido Intolerance to heat/cold Impotence

Urinary System

Kidney stones Painful urination Blood in urine Frequent urination Incontinence

Neurological

Paralysis Weakness Dizziness Loss of sensation Seizures Stroke
Tremor Memory loss Headache Speech Problems Balance Problems / Falling

Musculoskeletal

Gout Joint swelling Muscle weakness Abnormal movements / twitching
Back pain Joint pain/stiffness Muscle cramps Neck pain / stiffness

Skin

Rash skin ulcers itching blisters acne changing moles changes in skin color

Eye, Ear, Nose & Throat

Hoarseness Change in vision Ringing in ears Vertigo Sneezing Sore throat
Nose bleeds Loss of vision Hearing loss Sinus infections Oral Sores Runny nose

Mental Health

Anxiety Loss of interest in work Depressed mood Difficulty concentrating
Nervousness Thought of suicide Social withdrawal Loss of sexual desire
Hearing Voices Visual Hallucinations Fits of anger Obsessions

Gynecologic

Change in periods Severe Cramps Premenstrual mood swings Breast pain/lump Spotting
Vaginal Discharge Nipple discharge Pain during intercourse Excessive menstrual bleeding

Family History: Please circle any condition that has occurred in a blood relative and indicate the relationship (e.g. father, mother, sister, etc.)

Heart attack (at what age) _____ Emphysema _____ Diabetes _____

Rheumatoid arthritis _____ High blood pressure _____ Asthma _____

Crohn's disease _____ Colitis _____ Lupus _____

Colon cancer _____ Allergies _____ Stroke _____

Anemia (low blood) _____ Seizure or epilepsy _____ Tuberculosis _____

Irritable bowel disease _____ Breast cancer _____ Cirrhosis _____

Cholesterol problem _____ Easy bleeding/bruising _____ Alcoholism_____

Thyroid problem_____ Do any other diseases run in your family? _____

_____

_____

Medicines:

Are you allergic to or have you had a "bad reaction" to any medicines or other substance? ____No ____Yes

If Yes, list the medicines and reactions _____

_____

What medicines do you presently take? Include Drug name, dose, number of pills per day. (List here or attach)

_____

_____

_____

_____

_____

Do you take any non-prescription medicines or tonics? For example: laxatives, diet pills, vitamins, antacids, or cold remedies: _____No _____Yes If Yes, please list or attach: _____

_____

_____

Signed _____ **Date of Completion** _____

Thank you for completing this questionnaire