

Olympic Medical Center - Health Questionnaire

NAME: _____ DATE: _____ BIRTH DATE: _____

PAST MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING YES / NO

- Severe headaches
- Vision problems: What? _____ Last Exam? _____
- Epilepsy (Seizures) Neurologist? _____
- Diabetes? If Yes, is it under control? _____
- Radiation treatment to head or neck
- Thyroid or other gland problems
- Asthma / Allergy / Rhinitis; Skin tested? YES / NO
- Emphysema or Chronic Bronchitis
- Chronic cough
- Shortness of breath
- Tuberculosis
- Heart Disease, chest pain: Cardiologist? _____
- High Blood Pressure? If Yes, is it under control? _____
- Stroke
- Rheumatic Fever, Heart Valve Murmurs? YES / NO
- Blood Vessel problems: Where? _____
- Blood Clots (lungs or legs)
- Bruising or bleeding
- Anemia? If yes, what type? _____
- Ulcer: Scoped/Barium? Y / N GI specialist? _____
- Gall bladder problems
- Liver problems (hepatitis or jaundice)
- Bowels: constipation, diarrhea, bleeding, incontinent
- Kidney/ Bladder problems / leakage of urine
- Arthritis: What hurts? _____
- Nervous System Problems
- (circle) Depression, Anxiety, OCD, Manic, other?
- Memory Problems
- Sexual Function Problems
- Fatigue
- Weakness
- Numbness
- Falling down
- Weight Loss: How much/ over what time period? _____
- Weight Gain: How much/ over what time period? _____
- Skin issues: What? _____
- Cancer: Type? _____
- Sleep: _____ hours/day. Do you feel rested after? YES / NO

Last Colon CA screen (circle type): stool cards, barium enema, colonoscopy; who did it? _____ Date? _____

Marital Status: SINGLE MARRIED DIVORCED WIDOW
Are you sexually active? YES / NO

MEN ONLY

YES / NO Prostate Problems

- Penile / Testicular problems
- Herpes
- Venereal Warts
- STD
- Penile discharge
-

Method of birth control? _____

Do you use condoms? YES / NO

WOMEN ONLY

YES / NO

- Breast Problem, pain, lump, discharge
- Venereal Warts
- Herpes
- History of STD
- Problem with Uterus
- Problem with tubes or ovaries
- Did your mother take DES while pregnant?
- Had Paps in your lifetime? Date? _____
- Had abnormal Pap?
- Are your periods regular? Days bleeding? _____
of days in a cycle? _____
of pads or tampons? _____
- Bleeding between cycles
- Moderate or severe cramps
- PID (Pelvic Inflammatory Disease)
- Sweats; peri or menopausal symptoms:

Are you tolerating them? YES / NO

of pregnancies _____ # of miscarriages _____

of live births _____ # of abortions _____

Last menstrual period? _____

Method of birth control? _____

Do you use condoms? YES / NO

Other past methods of birth control? _____

Give Dates of SURGERIES, HOSPITALIZATIONS, serious injuries, or Medical problems being followed: _____

Name of Previous MD _____ Phone # _____ Last time seen there _____

Occupation: _____ Employer: _____

Patient Signature _____

PLEASE COMPLETE BOTH SIDES

