Bloomington
MEDICAL SERVICES

Health Questionnaire

Name: _____ **Date of Birth:** _____

Preferred Pharmacy:_____ **Location:** _____

Past Medical History

Please checkmark if you now have or have ever had any of the following medical problems listed

[ ] Adrenal Disorder
[ ] AIDS/HIV
[ ] Alcohol abuse
[ ] Allergies (seasonal/hay fever)
[ ] Anemia
[ ] Arthritis
[ ] Asthma
[ ] Atrial fibrillation
[ ] Back problems
[ ] Bone fractures
[ ] Bladder/UTI
[ ] Blood clots
[ ] Bleeding disorder
[ ] Blood transfusion
[ ] Breast lump or cyst
[ ] Breast cancer
[ ] Cancer
[ ] Cataracts
[ ] Carpal tunnel syndrome
[ ]Chronic bronchitis
[ ] Diabetes
[ ] Drug abuse
[ ] Emotional problems
[ ] Emphysema (COPD)
[ ] Gallstones
[ ] Glaucoma
[ ] Gastrointestinal problems
[ ] Goiter
[ ] Gout
[ ] Headaches/migraines
[ ] Hearing problems
[ ] Heart disease
[ ] Heart failure
[ ] Hepatitis A/B/C
[ ] High or low calcium
[ ] High blood pressure
[ ] High cholesterol
[ ] High Triglycerides
[ ] Hives
[ ] Hormone deficiency
[ ] Hypoglycemia
[ ] Infections-recurrent
[ ] Irritable bowel syndrome
[ ] Kidney disease
[ ] Kidney failure
[ ] Kidney stones
[ ] Liver disease
[ ] Lupus
[ ] Murmur (heart)
[ ] Neuropathy (nerve damage)
[ ] Osteoarthritis
[ ] Osteopenia
[ ] Osteoporosis
[ ] Pancreatitis
[ ] Parathyroid
[ ] Pituitary Issues
[ ] Pneumonia
[ ] Polycystic ovaries
[ ] Prostate issues
[ ] Reflux (GERD)
[ ] Rheumatoid arthritis
[ ] Seizures
[ ] Skin cancer
[ ] Stroke
[ ] Thyroid cancer
[ ] Thyroid disease
[ ] Tuberculosis
[ ] Tumors
[ ] Ulcers
[ ] Vascular disease
[ ] Vision problems
[ ] Vitamin deficiency
[ ] Valve problems (heart)

Other medical problems or details for above:

Please include approximate dates

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Hospitalizations and Surgeries

_____

_____

_____

_____

_____

_____

_____

_____

Social History

Tobacco [ ] current smoker [ ] former smoker [ ] never smoked Amount: _____

Alcohol [ ] yes [ ] no Type/Amount: _____

Illegal Drugs [ ] yes [ ] no

Exercise [ ] yes [ ] no Type/Frequency: _____

Allergies

Please list allergies to medications, dyes, latex, tape, etc.

Agent	**Reaction**	**Severity** *(mild, moderate, severe)*

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Family History

Please indicate which family members (eg. grandfather, mother, brother etc.) have the following:

[ ] Alcoholism
[ ] Anemia
[ ] Anesthesia –complications
[ ] Angina
[ ] Anxiety
[ ] Asthma
[ ] Arthritis
[ ] Autoimmune disorders
(ex. Lupus,RA)
[ ] Birth defects
[ ] Bleeding disorder
[ ] Blood clots
[ ] Blood transfusions
[ ] Bowel disease
[ ] Breast cancer
[ ] Cervical cancer
[ ] Colon cancer
[ ] Cancer-other
[ ] Depression
[ ] Diabetes
[ ] Heart attacks
(please state age at the time)
[ ] Heart disease
[ ] High blood pressure
[ ] High cholesterol
[ ] Hormone problems
[ ] Kidney disease
[ ] Liver disease
[ ] Melanoma
[ ] Mental disorders
[ ] Osteoporosis
[ ] Ovarian cancer
[ ] Parkinson
[ ] Psychiatric care
[ ] Respiratory disease
[ ] Seizures/Epilepsy
[ ] Severe allergies
[ ] Skin cancer
[ ] STD
[ ] Stroke
[ ] Suicide attempt
[ ] Thyroid disease
[ ] Ulcer disease
[ ] Uterine cancer

Other conditions or details from above: _____

_____

_____

_____

_____

Current Medications

Please include prescriptions, over-the-counter medicines, and vitamins/supplements

Medication Name	**Dose**	**Frequency** *(times per day)*