PHYSICIAN ASSOCIATES
ORLANDO HEALTH

HEALTH QUESTIONNAIRE

Patient's Name

MRN

DOB

Patient Name: _____

DOB: _____

Please indicate each of your chronic medical problems by marking the appropriate box below:

❑ High Blood Pressure	❑ Asthma	Please list any other medical problems:
❑ Heart Disease	❑ Emphysema/Lung Disease	
❑ Diabetes	❑ Kidney Problems	
❑ Stroke	❑ Anemia	
❑ Cancer	❑ High Cholesterol	
❑ Thyroid	❑ Glaucoma	

Please list all medications that you are now taking, strength (in milligrams) and how often. Include non-prescription medications, vitamins and herbal supplements.

Are you allergic to any medications? ❑ Yes ❑ No If yes, please list them and the reaction they cause.

Do you require assistance for hearing impaired? ❑ Yes ❑ No

Social History

Tobacco _____ a day

Alcohol _____ drinks per week

Street Drugs _____

Exercise _____ type

Water _____ cups a day

# of Children _____

Number of years _____ Year Quit _____

Caffeine _____ cups a day

Low fat diet ❑ Yes ❑ No

Times a week _____ minutes/session

Marital Status _____

Occupation _____

Do you have a living will? ❑ Yes ❑ No

If yes, have you given us a copy? ❑ Yes ❑ No

Family History

If any blood relative has suffered from the following conditions, check the box and indicate which relative.

❑ Heart Disease	❑ Stroke	❑ Asthma	❑ Glaucoma
❑ Diabetes	❑ High Blood Pressure	❑ Emphysema/Lung Disease	❑ Mental Health
❑ Thyroid	❑ High Cholesterol	❑ Cancer	❑ Substance Abuse

OVER

Patient Name:_____

Please list any surgeries/hospitalizations (including the year):

Are you under the care of any other doctor for any medical problems? _____

If so, whom and for what medical problem? _____

Year of last: Tetanus Shot _____ Flu Shot _____ Pneumonia Vaccine _____

Women only: Date of first day of last menstrual period: ___/___/___ Contraception Type _____

Number of: Pregnancies _____ Live Births _____

Miscarriages _____ Abortions _____

Date of last: PAP _____ (Abnormal?_____) Mammogram _____ (Abnormal?_____)

Date of last: Osteoporosis Scan _____ Flushing/Menopausal Symptoms ❑ Yes ❑ No

Have you been a victim of abuse? ❑ Yes ❑ No

Men only: Date of last: Prostate Exam _____ Last PSA (Prostate Blood Test) _____

Procedures (list year):

Sigmoidoscopy	Colonoscopy	Stress Test
EKG	Cholesterol (normal Y/N)	Sugar (normal Y/N)

Please place a checkmark next to any symptoms that you are currently having and indicate the year if the symptoms occurred in the past.

GENERAL	❑ Fever	❑ Night Sweats	❑ Unexplained Weight Loss or Gain	❑ Fatigue
SKIN	❑ Rashes	❑ Cancers	❑ Change in Hair, Skin or Nails	
EYES	❑ Glasses	❑ Contact Lenses	❑ Pain ❑ Changing Vision	❑ Discharge
EAR NOSE THROAT	❑ Ear Pain	❑ Change in Hearing	❑ Persistent Runny Nose	
	❑ Sore Throat	❑ Change in Voice	❑ Sinus Trouble	
HEART	❑ Chest Pain	❑ Swelling in Ankles	❑ Palpitations ❑ HeartMur mur	
LUNGS	❑ Cough	❑ Short of Breath	❑ Wheeze	
GASTRO-INTESTINAL	❑ Nausea	❑ Blood in Stool	❑ Change in Bowel Movements	
	❑ Ulcers	❑ Heartburn		
GENITO-URINARY	❑ Blood in Urine	❑ Painful or Frequent Urination	❑ Incontinence	
		❑ Sexually Transmitted Disease		
	Women:	❑ Vaginal Discharge	❑ Change in Menstrual Cycle or Sexual Function	
	Men:	❑ Testicular Pain	❑ Decreased Urinary Stream	
		❑ Penile Discharge	❑ Change in Sexual Function	
ORTHOPEDIC	❑ Painful Joints	❑ Muscle Weakness		
NEURO/PSYCH	❑ Seizures	❑ Tremor	❑ Paralysis ❑ Frequent Headaches	
	❑ Depression	❑ Anxiety		
ALLERGY	❑ Hives	❑ HayF ever		
CIRCULATION	❑ Leg Swelling	❑ Blood Clots		

Patient Signature _____ Date _____ Clinician Signature _____ Date _____