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Health Questionnaire

Today's Date: _____ Patient's Name: _____

Person Completing Questionnaire: _____

Relationship to patient: _____

Patient Contact: Day #: _____ Evening #: _____

Family Doctor's name and phone number: _____

Past Medical/Surgical History

Medical History/Procedure	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Relative:	Health Problems:
Father	_____
Mother	_____
Sisters (Number _____)	_____
Brothers (Number _____)	_____
Children (Number _____)	_____
Other (Grandparents, etc)	_____
_____	_____
_____	_____

List of your Medications. Include all herbal and over the counter medicines, aspirin, vitamins, inhalers, injections, eye drops, etc.

Medicine	Dosage	Times per day	Medicine	Dosage	Times per day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List all adverse food and drug reactions including allergy to soaps and latex:

Product	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social History

Do you/did you smoke? No Yes For how long? _____

If you quit, when? _____ Average packs per day _____

Do you/did you ever drink alcohol? No Yes If yes, average amount consumed per day _____

Do you/did you ever use Marijuana Cocaine Other illicit drug _____

If yes to any, when? _____

List your occupation (job) _____

Are you currently? Married Divorced Widow/Widower Not Married

Do you have children? Number _____

Did you graduate High School Technical School College Graduate School

Check all that apply:

Constitutional: No Problems

Poor Energy Fever Fatigue Change in Appetite Sweating

Has anyone hurt you in the past?

Eyes: No Problems

Blurred Vision Double Vision Glasses Contacts

Ears/Nose/Mouth/Throat: No Problems

Hoarse Voice

Hearing Impaired If yes, Hearing Aid

Ringing in the Ears Discharge from Ears Difficulty Smelling

Difficulty Swallowing Sinus Discharge

Hematologic/Lymphatic: No Problems

Enlarged Lymph Nodes Increased Bruising

Increased Bleeding Limb Swelling

Heart/Cardiovascular: No Problems

High Blood Pressure Abnormal Heart Rhythm Angina/Chest Pain

Previous Heart Attack Passing Out/Fainting Blood Clots/Phlebitis (DVT)

Lungs/Respiratory: No Problems

Hyperventilation Cold, Cough or Bronchitis now

Shortness of Breath Wheezing

Allergy/Immunology: No Problems

Adhesive Tape

Suture

Milk

Pollen

Latex

Betadine

Runny Nose

Gastrointestinal Stomach/Intestines/Liver: ___ No Problems
___ Abdominal Pain ___ Reflux/Heartburn ___ Constipation ___ Diarrhea
___ Blood in Stool ___ Incontinence of Stool

Genitourinary: ___ No Problems
___ Increased urge to urinate
___ Increased frequency of urination
___ Urinary Retention
___ Incontinence of Urine
___ Blood in Urine
___ Miscarriages
___ Difficulty with sexual functioning

Skin: ___ No Problems
___ Rashes
___ Changing moles
___ Ulcers

Endocrine: ___ No Problems
___ Recent Weight Gain
___ Recent Weight Loss
___ Increased Thirst
___ Heat or Cold Intolerance
___ Irregular Menses

Bones/Joints/Muscles: ___ No Problems
___ Joint Pain ___ Joint Swelling ___ Weakness ___ Back/Neck Pain

Neurologic: ___ No Problems
___ Headache ___ Excessive daytime sleepiness
___ Tremors ___ Problems with nighttime sleep
___ Poor Balance
___ Memory Loss
___ Trouble Thinking
___ Numbness/Tingling
___ Dizziness/Vertigo
___ Falling/Walking Difficulty

Psychiatric: ___ No Problems
___ Depressed
___ Anxious
___ Panic Attacks
___ Mood Changes
___ Hallucinations