COLETTE J. HO, MD, FACP
HEALTH QUESTIONNAIRE

Name_____Age_____ Date_____

Reason for seeing the doctor today_____

Please indicate below if you presently have, or have ever had any of the following medical problems.

__Diabetes mellitus
__High cholesterol
__High blood pressure
__Obesity
__Heart disease
__Stroke or mini-strokes
__Anorexia or bulimia
__Anxiety or depression
__Hay fever or allergies
__Asthma
__Positive PPD
__Other_____

__Anemia
__Osteoporosis or osteopenia
__Thyroid disease
__Irritable bowel syndrome
__Lactose intolerance
__Heartburn or esophageal reflux
__Stomach ulcers
__Colitis
__Polyps in the colon
__Hepatitis or other liver disease
__Headaches

__Lower back pain
__Epilepsy or seizures
__Arthritis or rheumatologic disease
__Kidney stones
__Kidney disease
__Prostate enlargement
__Cancer_____
__HIV+/AIDS
__Sexually transmitted diseases
__Pre-menstrual syndrome
__Fibroids

Drug allergies and any reactions to medications_____

Name, dosage, and frequency of any prescribed or over-the-counter medications that you presently use. Also, please list any alternative, natural, or herbal medications or vitamin supplements that you take, and any complementary therapies (e.g. acupuncture, chiropractor, massage, etc.) that you presently use.

_____

_____

_____

_____

_____

Have you had any surgery performed in the past? Please list the procedure(s) and the date(s) it was performed.

_____

_____

_____

Relationship, age, and medical history of parents and siblings.

_____

_____

_____

_____

Please indicate below if there is any family history of the following diseases.

__Early heart disease (angina or heart attack in a man prior to age 55 or in a woman prior to age 65) __Stroke
__Breast cancer __Ovarian cancer __Cervical cancer __Cancer of colon, stomach, or pancreas __Colitis
__Prostate cancer __Melanoma __Depression __Diabetes __High cholesterol __Hypertension
__Asthma __Osteoporosis __Thyroid disease __Rheumatologic disease __Other_____

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Have you experienced any of the following symptoms in the past month?

__Unusual fatigue
__Unusual weight loss
__Unusual weight gain
__Recurrent fevers
__Night sweats
__Eye irritation
__Vision changes
__Runny nose
__Ear pain or discharge
__Hearing loss
__Other_____

__Sore throat
__Difficulty swallowing
__Sinus congestion/pain
__Cough
__Shortness of breath
__Wheezing
__Hives
__Dizziness
__Chest pain or tightness
__Palpitations

__Swelling of the legs
__Headache
__Nausea/vomiting
__Abdominal pain
__Constipation
__Diarrhea
__Unusual thirst
__Change in urination
__Incontinence of urine
__Vaginal discharge /sore

__Rash
__Joint pain/swelling
__Back pain
__Weakness
__Numbness
__Depression
__Anxiety
__Abnormal bruising
__Enlarged lymph nodes
__Cold or heat intolerance

Approximate date of last tetanus shot_____ Have you ever had chicken pox in the past? yes no

Do you present smoke? yes no How much and for how many years?_____
If not, are you exposed to heavy secondhand smoke? yes no

Have you smoked in the past? yes no How much and for how many years?_____
What year did you stop?_____

Do you drink alcohol? yes no What kind?_____
How many drinks do you have in one week?_____

Describe what you do for exercise on a weekly basis_____

_____

List what you had to eat yesterday (include all meals and snacks)_____

_____

_____

_____

What is your present occupation?_____

If you were not born in the United States, in what country were you born? _____

Have you recently travelled out of the country? Yes no Where?_____

FOR WOMEN ONLY- GYNECOLOGICAL HISTORY-

Date of last menstrual period_____ Age of when you had your first menstrual period_____
Are periods regular? yes no Are periods very painful? yes no Are periods very heavy? yes no

For 1 week prior to your period, do you have increased symptoms of any of the following?
__Anxiety/depression/irritability __Headache __Bowel irregularities __ Bloating

How many times have you been pregnant?___ # of children___ # of abortions___ # of miscarriages
Complications during pregnancy_____

What birth control are you presently using? _____

Date of last PAP smear_____ Any abnormal PAP smears in past? yes no Any history of HPV? yes no
Date of last mammogram(if over 40 years old)_____ Any history of abnormalities? yes no
Date of last bone density test (if you are past menopause) _____