HEALTH QUESTIONNAIRE
NORTHWEST DIAGNOSTIC CLINIC

Patient Name: ____________________ Patient Date of Birth: _____________ Today's Date: ________
Physician: _________________________ Why are you here today? ______________________________

List Any Allergies and Reaction	**List Any Hospitalizations, Surgeries, or MD Visits In Last 12 Months (*Other than with NWDC*) If hospital – give reason for hospitalization.**

Please answer the following questions: (Check Answer)

Occupation: ____________________________________ Married Single Divorced Widowed (circle one)

Do you have children? Yes ☐ No ☐ If "Yes", how many? ____

Do you smoke? Yes ☐ No ☐ If "Yes", how many packs per day? ______________________________

Have you ever smoked? Yes ☐ No ☐ If "Yes" when did you quit? ____________________________________

How many packs per day? _____________________ If you are a smoker, are you interested in quitting? Yes ☐ No ☐

Do you consume alcohol? Yes ☐ No ☐ If "Yes", how much per day or week? __________________________

Do you consume caffeine? (Coffee, Tea, Soda) Yes ☐ No ☐ If "Yes", how much per day? ________________

PERSONAL HEALTH HISTORY *(Please check all items pertaining to your personal health history)*

☐ **Diabetes**
- ☐ Insulin Dependent ☐ Non Insulin Dependent
- When was your last eye exam? ______________________ With whom? __________________________
- When was your last foot exam? ______________________ With whom? __________________________

☐ **Diabetic Complications**
- ☐ Diabetic Retinopathy (*eye problems*) ☐ Diabetic Neuropathy (*nerve problems*)
- ☐ Diabetic Ulcers ☐ Diabetic Glaucoma, Cataract or Blindness ☐ Amputations Associated With Diabetes
- ☐ Peripheral Vascular Disease or Circulation problems due to Diabetes
- ☐ Other: ____

☐ **Heart Disease**
- ☐ Heart Attack or MI (Myocardial Infarction) When?_____________________________________
- ☐ Irregular Heart Beat ☐ Angina Stable or Unstable
- ☐ Congestive Heart Failure or Edema ☐ Other Heart Disease: __________________________
- Are you currently seeing a Cardiologist? Yes ☐ No ☐
- If "Yes", who is your Cardiologist?____

☐ **High Blood Pressure**
- ☐ Well controlled with medication ☐ Uncontrolled

☐ **Peripheral Vascular Disease**
- ☐ Circulatory Problems ☐ Other Circulatory Disorders
- ☐ Blood Clots or DVT ☐ Edema or Swelling or Pain in Legs
- ☐ Coagulation Disorder Are you on Coumadin or another blood thinner? ______________________

☐ **Respiratory**
- ☐ Chronic Asthma ☐ Emphysema
- ☐ Allergic Asthma ☐ Shortness of Breath
- ☐ Bronchitis ☐ Other: ____
- ☐ COPD

☐ **Cancer**
- List type: ____________________________________ Date Diagnosed: ______________________
- Current Treatment: ____
- Who is your Oncologist? _______________________ When was your last exam? _______________

☐ **Neurologic Disorder**

Seizure ☐ Stroke (CVA) ☐ Change in Speech or Vision ☐ Fainting or Dizziness ☐ Headaches/Migraines ☐

☐ **Psychologic Disorders**

☐ Depression or Anxiety ☐ Bi-Polar Disorder
☐ Suicidal Thoughts ☐ Other Mental Illness: ____________________ Treated by: ______________

☐ **Musculoskeletal**

☐ Arthritis ☐ Back or Neck Pain ☐ Joint Pain or Swelling
☐ Rheumatoid Arthritis ☐ Muscle Pain or Weakness
☐ Fracture Where: ______________________________ When: ______________________________
☐ Osteoporosis or Osteopenia When was your last bone density test? ______________________________

☐ **Gastrointestinal**

☐ Heartburn ☐ Chronic Diarrhea or Constipation ☐ Jaundice
☐ Abdominal Pain ☐ Dysphagia (Trouble Swallowing)
☐ Hepatitis What kind? ______________________ First Diagnosed? ______________________________

☐ **Fatigue:**

☐ Lumps or Masses ☐ Thyroid Disorder
☐ Irregular Periods Last Period: ___________________ ☐ Alcoholism
☐ Blood in Stools ☐ Epilepsy ☐ Aids/HIV ☐ Lupus or Other Autoimmune Disorder

☐ **Other:**

☐ Excessive thirst, hunger, or urination ☐ Heat or Cold Intolerance
☐ Weight Changes ☐ Bruising
☐ Hair Loss ☐ Anemia

IMMUNIZATIONS (Indicate year of last vaccination)

Tetanus __________ *(Recommended every 10 years)*
Pneumonia __________ *(Recommended every 5 years for age 50 and older/2 per lifetime)*
Hepatitis A _________ Hepatitis B ________ Influenza ________ Meningococcal _________

PREVENTATIVE EXAMS (Indicate year of last exam)

Colonoscopy __________ Mammography _________ Cholesterol _________ PSA ______________
Pap Smear/Gyn __________ Carotid Doppler ________ Eye Exam _________ Stress Test _________
TB Test _________ EKG ______ Bone Density ___________ Rectal Exam ________ Chest X-Ray _______

FAMILY HISTORY

☐ Diabetes Who? _______________ Are they still alive? Yes ☐ No ☐
☐ Heart Disease Who? _______________ Are they still alive? Yes ☐ No ☐
☐ Stroke Who? _______________ Are they still alive? Yes ☐ No ☐
☐ Seizure Disorder Who? _______________ Are they still alive? Yes ☐ No ☐
☐ Mental Illness Who? _______________ Are they still alive? Yes ☐ No ☐
☐ Other: _______________ Who? _______________ Are they still alive? Yes ☐ No ☐
☐ Cancer Who? _______________ Are they still alive? Yes ☐ No ☐

If "Yes", what kind of cancer?

____

List any other concerns:

____

____

Please check all that apply:

If you are experiencing or have experienced any of the following symptoms, please indicate "Yes" by checking the appropriate box.

Pain in joints ☐ If "Yes", which joints? ____

Swelling in joints ☐ If "Yes", which joints? ____

Rashes/Nodules ☐ If "Yes", where is the rash and/or nodule? ______________________________________

Dry eyes ☐ Dry mouth ☐ Hearing problems ☐ Enlarged lymph node ☐ Hoarseness ☐

Visual changes ☐ Ear pain ☐ Sinus Problems ☐ Muscle weakness ☐ Mouth ulcers ☐

Kidney disease ☐ Blood in urine ☐ Back stiffness ☐ Radiating pain ☐ Nocturia - #___ ☐

Gastric reflux ☐ Chest pain ☐ Palpitations ☐ Shortness of breath ☐ Pain with urination ☐

Wheezing ☐ Fever/Chills ☐ Stomach ulcer ☐ Headaches ☐ Loose stool/diarrhea ☐

Cough ☐ Fainting ☐ Nausea/vomiting ☐ Night sweats ☐ Depression ☐

Internal bleeding ☐ Hot flashes ☐ Cold intolerance ☐ Loss of bladder or bowel ☐ Anxiety ☐

Fatigue ☐ Heat intolerance ☐ Insomnia ☐ Do you get a rash when exposed to sunlight? ☐

Do your fingertips turn colors (blue, red, white) in the cold? ☐ Have you ever experienced a painful eye? ☐