Cynthia Taylor, MD

HEALTH SCREENING QUESTIONNAIRE

NAME _____ AGE _____ BIRTHDATE _____/_____/_____

Last Health Practitioner Consulted: _____ Date: _____/_____/_____

CONCERNS: What are your main problems or health concerns? Please describe, including how long, how changing over time, treatments tried. _____

_____

_____

_____

GOALS: What results would you like to accomplish here? _____

_____

PAST MEDICAL HISTORY: General state of health: Excellent Good Fair Poor

CHRONIC (ONGOING) PROBLEMS: _____

_____

_____

MAJOR OR SERIOUS ILLNESSES: _____

_____

_____

HOSPITALIZATIONS: (Date, reason, place) _____

_____

_____

SURGERIES: _____

_____

_____

MEDICATIONS: (List all prescription & over-the-counter medicines, herbs & supplements)

_____

_____

ALLERGIES: _____

LIFESTYLE & HABITS: Please check those which apply to you & specify amount

_____ Alcoholic beverages: _____Beers/week _____Wine/week _____ Mixed drinks/week _____Year Quit

_____ Tobacco products: _____Cigarettes/day _____ Cigars _____ Chew_____Years of use _____Year Quit

_____ Caffeinated beverages: _____cups coffee/day _____cups tea _____colas

_____ "Recreational" Drugs _____Marijuana _____ Cocaine _____ Stimulants (speed)

_____ Opiates _____ Other (describe)_____ Year Quit _____

_____ Have you ever taken drugs intravenously (IV-- by vein)? _____Shared a needle?

_____ Do you exercise regularly? What type?_____How long? _____ How often? _____

_____ Do you feel you have a healthy diet? Servings per day: _____Water _____Fruit _____Dairy

_____Green Vegetables _____Meat, fish, poultry _____Grains _____Fats _____Sweets

_____Do you have any hobbies? _____

_____

_____Do you have a regular spiritual practice? _____

_____Are you exposed to any hazards or toxins at work? _____

_____

_____Are there any animals living in your home? _____

_____Do you have sexual partner(s)? _____Male _____Female _____Both

_____Is there anything else the doctor should know about your lifestyle?

FAMILY HISTORY What part of the world are your ancestors from?_____

Member	**Age (Now) (at Death)**	**Health Problems or Cause of Death**
Mother		
Father		
Brother(s)		
Sister(s)		

Circle any health problems in your family, & specify which member(s):

High Blood Pressure Heart Disease Diabetes Asthma Allergies Arthritis
Stroke Epilepsy Depression Bipolar Disorder Alcoholism High Cholesterol
Cancer: Breast Ovary Colon Lung Other
Other: _____
Who: _____

STRESS FACTORS How much have the following been a problem for you:

	Alot	Quite A Bit	Some	None
Housing				
Money				
Violence in Home				
Alcohol				
Drugs				
Illness in Family				
Partner Relationship				
Sexuality				
Child(ren)				
Work Issues				
General Life Stress				

List the 3 most stressful events in your life in the last year:_____
_____
_____

SYMPTOMS Circle any problems or complaints you have experienced recently, or persistently:

GENERAL: Fever Weight changes Dizziness Chills Sweats Fatigue Weakness
HEAD: Eye problems Ear Problems Nasal congestion Hoarseness Dental pain
RESPIRATORY: Cough Shortness of Breath Wheezing
CARDIOVASCULAR: Chest Pain High Blood Pressure Abnormal heartbeat Swelling
GASTROINTESTINAL: Stomach pain Indigestion Nausea Vomiting Diarrhea
Constipation Blood in bowel movements Gas
URINARY: Trouble urinating Loss of urine Frequent urination Urinary pain or bleeding
GENITAL: (Women) Abnormal menstrual periods Vaginal discharge Breast lump
_____**# Pregnancies** _____**# Deliveries** _____**# Living children** Menopause symptoms
(Men) Trouble with erection Discharge from penis Lump in testicle Hernia
SKIN: Rash Hives Itching Changing Mole Non-healing sore
MUSCULOSKELETAL: Joint pain (location(s)):_____ Swelling
NERVOUS SYSTEM: Fainting Headaches Seizures Numbness Forgetfulness Depression
Trouble speaking Falling Anxiety Insomnia Racing Thoughts Hearing Voices

HEALTH MAINTENANCE Circle any tests you have had, & write most recent date(s):
Pap smear Mammogram Bone density scan Sigmoidoscopy Colonoscopy
Cholesterol Prostate Specific Antigen Stool Blood Tests Chest X-ray TB test
Immunizations: Flu Pneumonia Tetanus Hepatitis B Hepatitis A MMR