CASCADE PHYSICIANS, P.C.

HEALTH QUESTIONAIRE

Date: _____

Name: _____ Date of Birth: _____ Age:_____
Last First Initial

Reason for today's visit: _____

PERSONAL HISTORY:

Have you ever had:	yes/no		yes/no		yes/no
Anemia	☐ ☐	**Kidney Disease**	☐ ☐	**Appendectomy**	☐ ☐
Arthritis	☐ ☐	**Liver Disease**	☐ ☐	**Other Surgery** (Please list):	
Diabetes Mellitus	☐ ☐	**Thyroid Disease**	☐ ☐	_____	
Gallbladder Disease	☐ ☐	**Seizure/Epilepsy**	☐ ☐	_____	
High Blood Pressure	☐ ☐	**Stroke**	☐ ☐	_____	
Heart Disease	☐ ☐	**Ulcer Disease**	☐ ☐	_____	

Have you ever smoked? Y / N **If you smoke now, how many cigarettes a day? ____**
Coffee/Tea? Y / N **Approx. how many cups do you drink per day? ____**
Alcohol? Y / N **Average drinks per day? ____**
Other Drug use? _____

Drug Allergies: _____

List any medications that you take on a daily basis:

_____ _____ _____
_____ _____ _____
_____ _____ _____

When was your last Tetanus immunization _____ **Pneumovax** _____

FAMILY HISTORY: (please list any family members with the following problems & age when diagnosed)
Cancer _____ Heart Attacks _____ Other: _____
Diabetes _____ Hypertension _____ _____

CURRENT HEALTH CONCERNS: (circle all recent problems)

Fevers/Chills
Anxiety/Depression
Sadness/Change in moods
Cough
Shortness of Breath
Chest Pain
Abdominal Pain
Blood in stool
Diarrhea/Constipation
Frequent/Painful Urination
Nighttime urination (>1)
Headaches
Joint Pain/Swelling
Swelling in feet
Loss of consciousness
Memory Problems
Rash/Itching/Changing Mole
Vision/Eye concerns
Weight Gain/Loss
Heat/Cold Sensitivity
Sexual Problems
other: _____
_____

WOMEN ONLY:

(number of)
Pregnancies _____ Last menstrual period _____
Deliveries _____ Age at onset of menstruation _____
Abortions _____ Date of last PAP smear _____ Any abnormal pap? Y / N
Miscarriages _____ Form of contraception (if using) _____
Other: _____

Patient signature: _____ **Dr. Initial:** _____