

Health Profile

Name: _____ Date: _____

FAMILY HISTORY

FAMILY Print the names of your relatives, living or deceased, in the list below. If there is not enough space, place an (X) here:	YEAR OF BIRTH HEALTH STATUS Give the year of birth for all your relatives listed at the left and mark an (X) to indicate whether their health is good or poor.		ILLNESSES Place an (X) in the appropriate column for any illness that you or the relatives listed at the left have now or have had.						DEATHS If a relative you have listed has died, write the cause of death and the age at death in the columns below.	
	Year of Birth	Good	Poor	Heart Attacks	High Blood Pressure	Tuberculosis	Cancer	Diabetes	Cause of Death	Age
Father:										
Mother:										
Brothers and/or Sisters:										
Spouse:										
Children:										
Grandparents: (Mark an (X) for illnesses only.)										

LIFESTYLE

<input type="checkbox"/> Yes <input type="checkbox"/> No Do you use tobacco regularly? <input type="checkbox"/> Cigarette <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Chew If yes, how long? _____ How much? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Do you drink over 6 cups of coffee a day? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you drink alcohol regularly? <input type="checkbox"/> 1 oz per day <input type="checkbox"/> 2 oz per day <input type="checkbox"/> 4 oz per day <input type="checkbox"/> Over 4 oz per day Beer: <input type="checkbox"/> 1 bottle per day <input type="checkbox"/> 2 bottles per day <input type="checkbox"/> Over 2 bottles per day If you drink alcohol: <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever felt the need to cut down on your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you felt annoyed by criticism about your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had guilty feelings about your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you wear a seat belt regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you coping well with your stress?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you often feel depressed or down for more than a few days with no apparent cause? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you employed? If yes, what is your occupation? _____ How many hours do you work per week? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Do you regularly exercise? How? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any dietary restrictions? If so, what? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Are you up to date on immunizations? When was your last tetanus shot? _____ Flu shot? _____ Pneumonia shot? _____ How many meals do you eat per day? _____ How many hours of sleep do you get per night? _____ What are your major hobbies and recreational activities? _____ _____ How much recreational time do you allow yourself per day? _____ _____
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MEDICATIONS

List medications that you take (dose and frequency):

List allergies to any medications:

PAST HISTORY

List any surgeries and the year of occurrence: _____

List any significant diseases and the year of occurrence: _____

List any serious injuries or accidents and the year of occurrence: _____

REVIEW OF SYSTEMS

SKIN

Have you had any skin trouble – rashes, eczema, acne, skin cancer?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Have any skin growths or moles increased in size or changed color?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

List any other skin problems: _____

HEAD

Do you have severe headaches?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you have episodes of dizziness or numbness, tingling or weakness in any part of your body?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never

List any other head problems: _____

EYES - EARS

Do you have any trouble hearing?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you wear glasses or contacts?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you see double or does your eyesight black out?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never

When was the last time you had your eyes examined by an optometrist/ophthalmologist? _____

List any other eye or ear problems: _____

NOSE

Do you have any problems with allergies, sneezing or sinuses?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
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List any other nose problems: _____

MOUTH

List any mouth problems: _____

RESPIRATORY (CHEST)

Do you have asthma?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you cough?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you cough up sputum or phlegm?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Have you coughed up blood?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Have you had tuberculosis or lived with someone who had tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you get unusually short of breath with activity? Give an example: _____	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never

List any other respiratory (chest) problems: _____

CARDIOVASCULAR (HEART)

Have you had high blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had a heart attack?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have pains in your chest (angina) when walking, working or climbing stairs?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Does your heart beat irregularly or rapidly?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you have to prop up in bed at night to breathe?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you have cramping in your calves or thighs after walking?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never

List any other cardiovascular (heart) concerns: _____

GASTROINTESTINAL (STOMACH)

Have you had stomach ulcers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had gallstones or gallbladder trouble?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had jaundice (yellow eyes) or hepatitis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had rectal hemorrhoids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you experience rectal bleeding?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you experience constipation?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you experience indigestion?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never

List any other gastrointestinal (stomach) problems: _____

GENITO-URINARY (KIDNEY)

Have you had blood in your urine?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you have trouble starting or stopping your stream?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you have to get up more than once during the night to urinate?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you lose control of your bladder?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you use birth control? Which type: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

List any other genito-urinary (kidney) problems: _____

BONES – JOINT – MUSCLES

Are your joints painfully swollen or stiff?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Have you had serious back trouble?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you have arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

List any other bone, joint, or muscle problems: _____

ENDOCRINE (GLANDS)

Have you had any thyroid problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you hungry or thirsty at all times?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Do you urinate more than you think you should?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Have you had gout?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you gained or lost weight recently without trying? If so, how much? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

List any other endocrine (glands) problems: _____

GENERAL

Have you noticed any swelling or a lump in your neck, armpits or groin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble falling asleep or staying asleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a nervous breakdown?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ADDITIONAL QUESTIONS FOR MEN ONLY

Have you ever had any prostate gland trouble?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble with erections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

List any other male problems: _____

ADDITIONAL QUESTIONS FOR WOMEN ONLY

Are your periods irregular?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Do you have a lot of cramping with your period?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Have you, within the past year, had vaginal bleeding other than at the time of a period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had a lump in your breast?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever been pregnant? If yes, how many times? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Number of living children: _____			

When was the first day of your last period? _____ When was your last pap smear? _____

List any other female problems: _____

DENTAL

Have you had any pain in your jaw joints (pain in front of your ear)?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
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When was your last dental exam? _____

ADDITIONAL INFORMATION

Please list any other concerns or problems:
