Sally Suzanne Marie, MD

Health Questionnaire

Name _____ Date of birth ____/____/____ Today's Date _____

Occupation _____ SS# _____-___-_____ Age _____

Married ____ Single ____ Divorced ____ Widowed ____ Male ____ Female ____ Place of birth _____

Date of last exam _____ Last tetanus shot? _____ Who were you referred by? _____

Chief Complaint _____

*Do you have an Advanced Directive? Yes _____ No _____ [for office use only: Offered _____ DNR _____ CPR _____]

Drug Allergies

Current Meds (Include OTC & Vitamins)

Continue on back if necessary

Family History (please check ALL that apply)

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Drug Addiction	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐

Hospitalization or Surgery

Reason	Date	Reason	Date

Medical History (please check ALL that apply & give date of onset or procedure)

- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Heart Palpitations
- ☐ Heart Murmur
- ☐ Irregular Heart Rate
- ☐ Chest Pain / Angina
- ☐ Heart Attack
- ☐ Stroke / TIAs
- ☐ Peripheral Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Birth Defect of the Heart
- ☐ Headaches
- ☐ Alcoholism
- ☐ Dizziness / Fainting
- ☐ Anxiety / Depression
- ☐ Fatigue
- ☐ Shortness of Breath
- ☐ Foot Problem
- ☐ Allergies / Hay fever
- ☐ Asthma
- ☐ COPD / Emphysema
- ☐ Pneumonia
- ☐ Sexually Transmitted Disease
- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ Sleeping Problem / Insomnia
- ☐ Ulcer
- ☐ Heartburn / GI Disorder
- ☐ Sexual Problem
- ☐ Menstrual Problem
- ☐ Bladder Problem
- ☐ Anemia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Diabetes
- ☐ Thyroid / Endocrine Disease
- ☐ Cancer
- ☐ Transfusion

Tobacco products: Type & Amount daily _____ Interested in quitting? Yes ____ No ____

Have you ever used "recreational drugs"? Yes ____ No ____ if yes, what type: _____

Alcohol: Type & Amount daily _____ Coffee/Caffeine: Amount daily _____

Do you like your work? Yes ____ No ____ Hobbies/Sports: _____

Exercise routine: _____

Women only:

Date of last period _____ Pregnancies/Live births: ____/____ Birth control method: _____

Planning pregnancy? Yes ____ No ____

Men only: Do you occasionally experience erection difficulties? Yes ____ No ____

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NAME_____ **Date of Birth**_____

EMAIL:_____

In order to comply with the new Health Care Mandates we have been asked to collect the following information.

RACE: (Please choose only one)

- American Indian or Alaska Native
- Asian
- Native Hawaiian
- Black or African American
- White
- Hispanic
- Pacific Islander
- Other
- Refused

ETHNICITY: (Please choose only one)

- Hispanic
- Non-Hispanic
- Refused

PREFERRED LANGUAGE: (Please choose only one)

- English
- Indian (includes Hindi & Tamil)
- Spanish
- Korean
- Other
- Refused