Dr. ZUKE'S HEALTH QUESTIONNAIRE Date: _____

Name: _____ Date of Birth: _____ Age: _____ Sex: M F

Height: _____ Weight: _____ Reason for today's visit: _____

Please list or provide a list of all surgeries or hospitalizations (please include dates): _____
_____

Please list or provide a list of ALL current medications and dosages-including over the counter medications, vitamins, and herbal medications:_____
_____
ALLERGIES to medications: _____
_____

Have YOU or any of your RELATIVES (please list which relative) had any of the following?
Stroke: Y N_____ Heart Attack: Y N_____ High Blood Pressure: Y N _____
Cancer: Y N_____ Diabetes: Y N_____ Hernias: Y N_____ Gallstones: Y N_____

Occupation: _____ Marital Status: S M Sep D W # of Children_____
Tobacco: CURRENT USER (Type-cigarettes, cigars, chew, pipe: _____Amount per day or week: _____# of years: _____)
NEVER FORMER (date quit-_____amount used per day or week-_____)
Alcohol: CURRENT USER (Amount: _____Type beer, wine, liquor - _____# of years-_____)
NEVER FORMER (date quit-_____)
Are you on a special Diet? Y N Type: _____

Are you now having, or currently being treated for any of the following medical conditions?

Constitutional

Fever	Y N
Chills	Y N
Weight loss	Y N
Malaise/Fatigue	Y N
Excessive Sweating	Y N
Weakness	Y N

Skin

Rash	Y N
Itching	Y N

HENT

Hearing loss	Y N
Ringing in the ears	Y N
Nosebleeds	Y N
Sore throat	Y N

Eyes

Blurred vision	Y N
Double vision	Y N

Cardiovascular

Chest pain	Y N
Irregular heartbeat	Y N
Leg swelling	Y N

Respiratory

Cough	Y N
Shortness (breath)	Y N
Wheezing	Y N

GI

Heartburn	Y N
Nausea	Y N
Vomiting	Y N
Abdominal Pain	Y N
Diarrhea	Y N
Constipation	Y N
Blood in stool	Y N
Black stool	Y N

Urology

Burning	Y N
Urgency to urinate	Y N
Frequency	Y N
Blood in urine	Y N
Flank pain	Y N

Musculoskeletal

Muscle aches	Y N
Back pain	Y N
Joint pain	Y N

Endocrine/hematology

Easily bruise or bleed	Y N
Environmental allergies	Y N
Excessive Thirst	Y N

Neurological

Dizziness	Y N
Tingling	Y N
Tremor	Y N
Seizures	Y N
Headaches	Y N

Psychiatric

Depression	Y N
Suicidal ideas	Y N
Substance abuse	Y N
Nervous/Anxious	Y N
Memory Loss	Y N