

Dr.Guerra's Health Questionnaire

Date _____

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

Height _____ Weight _____ Reason for Visit _____

Allergic to any medications: ___ Yes No ___ Please List: _____

Please list or provide a list of medications and dosages you are currently taking. Please include any over the counter medications or any diet or herbal supplements.

Surgical History:

Do you have a personal history of cancer? _____ If so, what type? _____

Family History: Who if anyone, in your family has had any of the following?

Diabetes _____ Heart Disease _____ Cancer _____ Stroke _____

Social History: What is your occupation? _____ Full or Part-time? _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Do you drink alcohol? Never _____ Rarely _____ Moderate _____ Daily _____

Do you use Tobacco? Never _____ Previously, but quit _____ Currently _____, Packs per day _____

Use of Illegal/street drugs? Never _____ Currently _____, type/frequency _____

Are you on a special diet? _____, Type _____

Review of Systems: Do you now or have you ever had any problems related to the following?

Constitutional

Fever Y N
Chills Y N
Night sweats Y N

Endocrine

Diabetes Y N
Thyroid Problems Y N
Gout Y N

Genitourinary

Bladder Infections Y N
Kidney Stones Y N
Kidney Failure Y N

Eyes

Visual Changes Y N
Glaucoma Y N

Respiratory

Pneumonia Y N
Asthma Y N
Emphysema Y N
Tuberculosis Y N

Musculoskeletal

Back Pain Y N
Osteoporosis Y N
Arthritis Y N

ENT

Sinus/Allergies Y N
Loss of Hearing Y N

Cardiovascular

Heart Attack Y N
Angina/chest Pain Y N
Heart Failure Y N
Mitral Valve Prolapse Y N
Atrial Fibrillation Y N
High Blood Pressure Y N
Stroke/TIA Y N
Aneurysm Y N
Raynaud's Disease Y N

Gastrointestinal

Abdominal Pain Y N
Indigestion Y N
Stomach Ulcers Y N
Hepatitis Y N
Irritable Bowel Y N
Blood In Stool Y N

Integument/Breast

Skin Rash Y N
Non-healing sore Y N
Breast Lump Y N

Hematologic/Lymph

Anemia Y N
Sickle Cell Y N
Blood Clots Y N

Neurological

Dizzy Spells Y N
Seizures Y N
Headaches Y N
Multiple Sclerosis Y N
Head Injury Y N

Aids/HIV

Enlarged Lymph Node Y N

Lupus Y N

Additional Medical Illness

