

J. Chris Beckman, M.D., PLLC

Family Medicine Health Questionnaire

Patient's Name

Today's Date

Do you or have you had **persistent** problems with the following?

SKIN:

Rashes Yes No
Hair or nails Yes No
Do you have any tattoos? Yes No

HEAD:

Headache Yes No
Head injury Yes No
Blackouts Yes No
Dizziness Yes No
Memory Loss Yes No
Depression Yes No
Nervousness Yes No

EYES:

Wear glasses/contacts Yes No
Blurred vision Yes No
Cataracts Yes No
Date of last eye exam: _____

NOSE/EARS:

Allergies Yes No
Sinus trouble Yes No
Hearing loss Yes No
Ringing in ears Yes No

MOUTH:

Wear dentures? Yes No
Hoarseness Yes No
Gums Yes No
Date of last dental exam: _____

NECK:

Goiter/thyroid Yes No
Swollen "glands" Yes No

EXTREMITIES:

Joint pain/swelling Yes No
Gout Yes No
Numbness/tingling Yes No
Varicose veins Yes No
Phlebitis Yes No
Back trouble Yes No

LUNGS:

Persistent cough Yes No
Cough up blood Yes No
Emphysema/Bronchitis Yes No
Pneumonia Yes No
Last chest x-ray: _____

BREASTS:

Lumps Yes No
Nipple discharge Yes No
Do self-exam? Yes No
Date of last mammogram: _____

HEART:

Chest pain w/exercise Yes No
Shortness of breath Yes No
Heart murmur Yes No
Sleep on more than 1 pillow? Yes No
Swelling of ankles? Yes No
Last EKG: _____

GASTROINTESTINAL:

Trouble swallowing Yes No
Heartburn/ulcer Yes No
Vomiting Yes No
Diarrhea Yes No
Constipation Yes No
Bloody/black stools Yes No
Hemorrhoids Yes No
Hepatitis Yes No

URINARY:

Frequent urination Yes No
Trouble starting Yes No
Urinate during night Yes No
Leakage Yes No
Blood in urine Yes No
Kidney stones Yes No
Infections Yes No

GENERAL:

Blood transfusion Yes No
Rheumatic fever Yes No
Usual weight: _____ pounds
Do you have a living will? Yes No

SEXUAL:

Problems with sex Yes No
Multiple partners Yes No
History of V.D. Yes No

FEMALES:

Painful periods Yes No
Irregular periods Yes No
On birth control pills Yes No
Form of contraception used: _____
Age started periods: _____
Number of pregnancies: _____
Number of children: _____
Number of Miscarriages: _____
Date of last Pap smear: _____
Date of last period: _____

IMMUNIZATIONS: (Date of last ...)

Tetanus shot: _____
Pneumonia shot: _____
Flu shot: _____
Hepatitis B series: _____