Comprehensive Health Examination Questionnaire

Name: ____________________________________ Date: _________________________

What problem(s) do you wish to address today?____

____

Problem(s) for future visit(s)? ____

Present, Ongoing Medical Problems: ____

MEDICATION ALLERGIES: ____

Current Prescriptions/Doses: ____

What prescriptions do you want today? ____

Herbs & Supplement Taken Regularly: ____

Food Allergy or Intolerance: ____

FAMILY HISTORY

	Age if Alive	Illnesses	Age at Death	Cause(s)
Father	________	____________________	________	________________
Mother	________	____________________	________	________________
Spouse	________	____________________	________	________________
Brothers	________	____________________	________	________________
	________	____________________	________	________________
Sisters	________	____________________	________	________________
	________	____________________	________	________________
Sons	________	____________________	________	________________
	________	____________________	________	________________
Daughters	________	____________________	________	________________
	________	____________________	________	________________

SOCIAL HISTORY

Birth Place: __________________ Raised in: ________________ Education: _____________

Occupation: ____________________ Hobbies: ___________________

PLEASE TURN OVER & COMPLETE THE BACK SIDE

PAST HISTORY

Type & date of **significant** injuries requiring medical attention? ______________________________________

____

Type & date of **significant** past illnesses needing hospitalization, emergency room visit or repeated doctor visits? ____

What surgeries & approximate dates? ____

EXERCISE:

Regular physical activity? NO or minutes of ____________________ ____ times per week for ______ months.

TOBACCO:

Never __ Quit in 19__ after smoking __ packs per day for ___ years.
I have smoked __ packs per day for __ years.

ALCOHOL:

Male: More than 14 drinks per week or 4 drinks per occasion? Never __ . Yes ___.
Female: More than 7 drinks per week or 3 drinks per occasion? Never __ . Yes ___.
Has your alcohol use ever concerned you, a friend, or family member? Never __ . Yes ___.

CAFFEINE:

None __ or ____ drinks of ____per day.

LAST IMMUNIZATIONS: Tetanus ____ Influenza ____ Pneumovax ____

Last Complete Medical Exam was ____ by Dr. ____________________ who advised: ____________________

At today's visit, do you wish to discuss sexual function or health? Yes ___ No __

Do you have? **Durable Power of Attorney**? _____. **Living will**? _____.

Anything else I should know? ____

Thank you, Signature: ____________________

Earl J. Carstensen, MD
06/08/05

New patients who have late cancellations or miss appointments will not be rescheduled.