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**Health Questionnaire**

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Preventive care is an important part of your health care. The following questions address your lifestyle and will assist you and your physician to implement healthy habits.

Do you now or have you ever smoked cigarettes?      YES      NO		
If currently smoking, how much and frequency?		
If you are not now smoking, what was your quit date?		
Do you drink alcohol?      YES      NO		
If yes, how many drinks per week on average?		
Have you ever needed to cut down your drinking?      YES      NO		
Have you ever felt guilty about your drinking?      YES      NO		
Have you ever felt annoyed when people criticized your drinking?      YES      NO		
Do you currently use recreational drugs?      YES      NO		
Have you in the past used recreational drugs?      YES      NO		
Do you use sunscreen?      YES      NO		
Do you exercise regularly?      YES      NO		
If so, type:	Duration:	Frequency:
Do you wear a bicycle helmet?      YES      NO		
Do you have guns in the home?      YES      NO		
How many servings of fruits and vegetables do you have daily?		
How many servings of dairy products do you have daily?		
How many servings do you eat weekly of the following:		
Red meat _____		
Chicken _____		
Fish _____		
Fast foods _____		
Do you feel that you overeat?      YES      NO		

How many cups of caffeine-containing beverages do you have daily?

\_\_\_\_\_

Have you completed a health care proxy?            YES            NO

\_\_\_\_\_

Do you currently have significant problems with the following?:

FATIGUE	YES	NO	CHEST PAINS	YES	NO
WEIGHT LOSS	YES	NO	SHORTNESS OF BREATH	YES	NO
FALLS	YES	NO	PALPATATIONS	YES	NO
HEARING	YES	NO	EXERCISE INTOLERANCE	YES	NO
VISION	YES	NO	FAINING	YES	NO
SWALLOWING	YES	NO	COUGH	YES	NO
NASAL/SINUS CONGESTION	YES	NO	WHEEZING	YES	NO
APPETITE LOSS	YES	NO	SNEEZING	YES	NO
HEARTBURN	YES	NO	URINATION DIFFICULTY	YES	NO
ABDOMINAL PAIN	YES	NO	NIGHT-TIME URINATION	YES	NO
JOINT PAINS	YES	NO	INVOLUNTARY LOSS OF URINE	YES	NO
JOINT SWELLING	YES	NO	LOSS OF USUAL INTERESTS	YES	NO
PROLONGED MORNING STIFFNESS	YES	NO	EXCESSIVE SADNESS	YES	NO
HEADACHES	YES	NO	ANGER/IRRITABILITY	YES	NO
			SLEEP DISTURBANCE	YES	NO

OTHER:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list current medications, dosages, and how taken daily:**

Prescription medications (including skin and eye)	Over the counter medication, vitamins, herbs:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**FOR PHYSICIAN ONLY**

Medications: patient list reviewed Additions/changes:	Non prescription:
_____	_____
_____	_____
_____	_____