Judy L Bourget MD, Inc.

# HEALTH QUESTIONNAIRE

Name: ______________________ Age: _______ Date: ______________

**PAST MEDICAL HISTORY:** SSN:______________ Date of Birth:______________

| Condition | | | Condition | | | Condition | | |
|---|---|---|---|---|---|---|---|---|
| Measles………………………… | NO | YES | Seizure………………………….. | NO | YES | Peptic Ulcer…………….. | NO | YES |
| Mumps………………………….. | NO | YES | Heart Disease……………... | NO | YES | Kidney Disease………… | NO | YES |
| Chicken Pox…………………… | NO | YES | Hypertension…………….. | NO | YES | Diabetes………………… | NO | YES |
| Polio…………………………….. | NO | YES | Tuberculosis……………… | NO | YES | Thyroid Disease……….. | NO | YES |
| Rheumatic Fever……….…..... | NO | YES | Pneumonia………………… | NO | YES | Venereal Disease………. | NO | YES |
| Scarlet Fever………………….. | NO | YES | Asthma……………………. | NO | YES | Anemia…………………. | NO | YES |
| Cancer………………………….. | NO | YES | Hepatitis………………….. | NO | YES | Phlebitis/Blood Clot……. | NO | YES |
| Stroke…………………........... | NO | YES | Liver Disease…………….. | NO | YES | Gout…………………….. | NO | YES |

**Significant illnesses, injuries, or hospitalizations:**

Year: ________ Illness: ______________________
Year: ________ Illness: ______________________
Year: ________ Illness: ______________________
Year: ________ Illness: ______________________

**PAST SURGERIES:**

Year: ________ Surgery: ______________________
Year: ________ Surgery: ______________________
Year: ________ Surgery: ______________________
Year: ________ Surgery: ______________________

**Allergies: (Medication & Food)**

1.______________________ Reaction ______________________
2.______________________ Reaction ______________________
3.______________________ Reaction ______________________
4.______________________ Reaction ______________________

**Current Medications:**

1.______________________ 5.______________________
2.______________________ 6.______________________
3.______________________ 7.______________________
4.______________________ 8.______________________

**Immunizations:**

| Year: | |
|---|---|
| | Influenza |
| | Tetanus |
| | Pneumococcus |
| | Gardisil |
| | |
| | |

**Social History:**

| |
|---|
| Marital Status: S M Sep D W #______________ children |
| Occupation: Hrs/Wk:______________ |
| Job Satisfaction: □ Yes □ No Smoker: □ Yes □ No Pack/Day: #_________ Years: #_________ |
| Caffeine: □ Yes □ No Cups/Drinks: _________ Day |
| Alcohol: (Kind, Amount, Frequency) |
| Recreational Drugs: |
| Advance Directive/Living Will: □ Yes □ No |

| Family History | Age | If Living: Health Status | If Deceased: Age ( at death ) & Cause | | Has any blood relative ever had: | | |
|---|---|---|---|---|---|---|---|
| Father | | | | | Cancer | NO | YES |
| Mother | | | | | Tuberculosis | NO | YES |
| Brother/Sister | | | | | Diabetes | NO | YES |
| | | | | | Heart Trouble | NO | YES |
| | | | | | High Blood Pressure | NO | YES |
| | | | | | Stroke | NO | YES |
| Husband/Wife | | | | | Convulsions | NO | YES |
| Son/Daughter | | | | | Suicide | NO | YES |
| | | | | | Mental Illness | NO | YES |
| | | | | | Bleeding Tendency | NO | YES |
| | | | | | Osteoporosis | NO | YES |
| | | | | | Gout or Arthritis | NO | YES |