pinnacle
MEDICAL GROUP, INC.

Health Questionnaire

Complete both sides of this form for first time examinations
and the reverse side only for repeat examinations.

PMG-532 (5/98)
Questionnaire
Health Adult

Patient Name ____________________
Date ____________________
Address ____________________
Home Phone # ____________ Work Phone # ____________

PERSONAL HISTORY

Birthplace ____________ Date of Birth ____________ Age ______
Nationality ____________ Religion ____________
Marital Status ____________ Health of spouse ____________
Occupations ____________

Residence past 5 years ____________
Education through ________ grade Sleep (usual hrs.) ________ Aids to sleep ______
Recreation ____________
Exercise ____________
Average per day:
Alcohol (type) ____________
Tea, Coffee ____________
Tobacco (type) ____________
What is your past smoking history? ____________
Do you wear seat belts? yes _______ no _______
What is your past occupational lung exposure? ____________

Medicines taken regularly	Dose	Frequency	Reason

PERSONAL PAST HISTORY (Circle "yes" or "no". If "yes" give year of occurrence.)

HAVE YOU EVER HAD:			YEAR
MEASLES	YES	NO	
MUMPS	YES	NO	
WHOOPING COUGH	YES	NO	
POLIO	YES	NO	
SCARLET FEVER	YES	NO	
DIPHTHERIA	YES	NO	
MENINGITIS	YES	NO	
INFECTIOUS MONO	YES	NO	
VALLEY FEVER	YES	NO	
TUBERCULOSIS	YES	NO	
EXPOSURE TO TB	YES	NO	
MALARIA	YES	NO	
VENEREAL DISEASE	YES	NO	
ARTHRITIS	YES	NO	
BACK TROUBLE	YES	NO	
BRONCHITIS	YES	NO	
PNEUMONIA	YES	NO	
PLEURISY	YES	NO	
ASTHMA	YES	NO	
EMPHYSEMA	YES	NO	
RHEUMATIC FEVER	YES	NO	
HIGH BLOOD PRESSURE	YES	NO	
HEART DISEASE	YES	NO	
STROKE	YES	NO	
SEIZURES	YES	NO	
MIGRAINE HEADACHES	YES	NO	
HIVES	YES	NO	
HAY FEVER/SINUSITIS	YES	NO	
GLAUCOMA	YES	NO	
NOSE BLEEDS	YES	NO	
ANEMIA	YES	NO	
BLEEDING TENDENCY	YES	NO	
BLOOD TRANSFUSION	YES	NO	
DIVERTICULOSIS	YES	NO	
ALCOHOLISM	YES	NO	
PANCREATITIS	YES	NO	
HEPATITIS (YELLOW JAUNDICE)	YES	NO	
GALL STONE	YES	NO	
ULCER	YES	NO	
HEMORRHOIDS	YES	NO	
BLADDER INFECTIONS	YES	NO	
KIDNEY DISEASE	YES	NO	
KIDNEY STONE	YES	NO	
PELVIC DISEASE	YES	NO	
DIABETES	YES	NO	
THYROID DISEASE	YES	NO	
CANCER	YES	NO	

ALLERGIES TO MEDICATIONS
LIST: ____________

OTHER ALLERGIES: ____________

IMMUNIZATIONS:			YEAR
TETANUS	YES	NO	
POLIO SHOTS	YES	NO	
POLIO ORAL	YES	NO	
MEASLES	YES	NO	
PNEUMONIA	YES	NO	
INFLUENZA	YES	NO	
HEMOPHILUS	YES	NO	
TB TEST POSITIVE?	YES	NO	

INJURIES:		
HEAD	YES	NO
CHEST	YES	NO
ABDOMEN	YES	NO
BROKEN BONES	YES	NO
BACK / NECK	YES	NO
OTHER	YES	NO

OPERATIONS:		
TONSILS	YES	NO
APPENDIX	YES	NO
GALL BLADDER	YES	NO
STOMACH	YES	NO
BREAST	YES	NO
UTERUS AND/OR OVARY	YES	NO
PROSTATE	YES	NO
HERNIA	YES	NO
THYROID	YES	NO
VARICOSE VEINS	YES	NO
HEMORRHOIDS	YES	NO
HEART	YES	NO
OTHER	YES	NO

OTHER SERIOUS ILLNESS: ____________

Name: ____________

FAMILY HISTORY – Has any blood relative had any of the following:
Circle "yes" or "no"–If so, what relationship:

Anemia	yes	no	
Asthma	yes	no	
Bleeding tendency	yes	no	
Cancer (Type)	yes	no	
Chronic lung disease	yes	no	
Chronic diarrhea	yes	no	
Convulsions or fits	yes	no	
Diabetes	yes	no	
Gout	yes	no	
Heart disease	yes	no	
High blood pressure	yes	no	
Kidney disease	yes	no	
Leukemia	yes	no	
Mental illness	yes	no	
Migraine headaches	yes	no	
Obesity	yes	no	
Peptic ulcer	yes	no	
Repeated Infections	yes	no	
Severe allergies	yes	no	
Thyroid trouble	yes	no	
Tuberculosis	yes	no	

	Present Age	Age at Death	If living, health (good, fair, poor) if deceased, cause of death
Father			
Mother			
Brothers or Sisters			
1.			
2.			
3.			
4.			
5.			
6.			
7.			
Children			
1.			
2.			
3.			
4.			
5.			
6.			

Others who live at your house

Relationship	Health
1.	
2.	

Doctors Notes

WISHED RE LIFE SUPPORT

____I would never want resusitation or life support.

____I would want resusitation or life support only if something happened that was easily correctable.

____I would always want everything possible done to prolong my life even if I were in a permanent coma.

____I have a DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

____I would like to fill out a DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

History # ____________

PATIENT NAME: ____________________________

SYSTEMS REVIEW

HAVE YOU RECENTLY HAD THE FOLLOWING?
CIRCLE "YES" OR "NO"; IF IN DOUBT, LEAVE BLANK.

Please complete this side for repeat examinations.

GENERAL		
TIRE EASILY, WEAKNESS	YES	NO
MARKED WEIGHT CHANGE	YES	NO
NIGHT SWEATS	YES	NO
PERSISTENT FEVER	YES	NO
SENSITIVITY TO HEAT	YES	NO
SENSITIVITY TO COLD	YES	NO
SKIN		
ERUPTIONS (RASH)	YES	NO
CHANGE IN COLOR	YES	NO
CHANGE IN HAIR	YES	NO
CHANGE IN NAILS	YES	NO
EYES		
TROUBLE SEEING	YES	NO
EYE PAIN	YES	NO
INFLAMED EYES	YES	NO
DOUBLE VISION	YES	NO
WORN GLASSES	YES	NO
EARS		
LOSS OF HEARING	YES	NO
RINGING IN EARS	YES	NO
DISCHARGE	YES	NO
NOSE		
LOSS OF SMELL	YES	NO
FREQUENT COLDS	YES	NO
OBSTRUCTION	YES	NO
EXCESS DISCHARGE	YES	NO
NOSEBLEEDS	YES	NO
MOUTH		
SORE GUMS	YES	NO
SORENESS OF TONGUE	YES	NO
DENTAL PROBLEMS	YES	NO
THROAT		
POSTNASAL DRAINAGE	YES	NO
SORENESS	YES	NO
HOARSENESS	YES	NO
BREASTS		
LUMPS	YES	NO
DISCHARGE	YES	NO
CARDIO-RESPIRATORY SYSTEM		
COUGH, PERSISTING	YES	NO
SPUTUM (PHLEGM)	YES	NO
BLOODY SPUTUM	YES	NO
WHEEZING	YES	NO
CHEST PAIN OR DISCOMFORT	YES	NO
PAIN ON BREATHING	YES	NO
SHORTNESS OF BREATH	YES	NO
DIFFICULTY BREATHING WHILE LYING DOWN	YES	NO
SWELLING OF ANKLES	YES	NO
BLUISH FINGERS OR LIPS	YES	NO
HIGH BLOOD PRESSURE	YES	NO
PALPITATIONS	YES	NO
VEIN TROUBLE	YES	NO
ENDOCRINE		
THYROID TROUBLE	YES	NO
ADRENAL TROUBLE	YES	NO
CORTISONE TREATMENT	YES	NO
DIABETES	YES	NO

GYN-OB

Started menstruating at age __________. Date of last PAP test __________

Interval between periods __________ days Duration __________ days

Flow: light normal heavy Date of last period __________

Pain with periods: yes no duration __________

Number of pregnancies __________ Number of miscarriages __________ Number of births __________

Weight of babies at birth __________

Contraception __________ Last Mammogram __________

Frequency of Breast Self Examination __________

GASTRO-INTESTINAL		
CHANGE IN APPETITE	YES	NO
DIFFICULTY SWALLOWING	YES	NO
HEARTBURN	YES	NO
ABDOMINAL DISTRESS	YES	NO
BELCHING OR EXCESS GAS	YES	NO
ABDOMINAL ENLARGEMENT	YES	NO
NAUSEA	YES	NO
VOMITING	YES	NO
VOMITING OF BLOOD	YES	NO
RECTAL BLEEDING	YES	NO
TARRY STOOLS	YES	NO
DARK URINE	YES	NO
JAUNDICE	YES	NO
CONSTIPATION	YES	NO
DIARRHEA	YES	NO
HEMORRHOIDS	YES	NO
NEEDS FOR LAXATIVES	YES	NO
GENITOURINARY SYSTEM		
INCREASE IN FREQUENCY OF URINATION (DAY)	YES	NO
DISCOMFORT WITH URINATION	YES	NO
INCREASE IN FREQUENCY OF URINATION (NIGHT)	YES	NO
FEEL NEED TO URINATE WITHOUT MUCH URINE	YES	NO
UNABLE TO HOLD URINE	YES	NO
BLOOD IN URINE	YES	NO
PROTEIN IN URINE	YES	NO
PELVIC PAIN	YES	NO
DISCHARGE FROM VAGINA	YES	NO
VAGINAL ITCH	YES	NO
IMPOTENCE	YES	NO
LACK OF SEX DRIVE	YES	NO
PAIN WITH INTERCOURSE	YES	NO
LOCOMOTOR		
MUSCLE CRAMPS	YES	NO
MUSCLE WEAKNESS	YES	NO
PAIN IN JOINTS	YES	NO
SWOLLEN JOINTS	YES	NO
STIFFNESS	YES	NO
DEFORMITY OF JOINTS	YES	NO
NECK PAIN	YES	NO
BACK PAIN	YES	NO
NERVOUS SYSTEM		
HEADACHES	YES	NO
DIZZINESS	YES	NO
FAINTING	YES	NO
CONVULSIONS OR FITS	YES	NO
NERVOUSNESS	YES	NO
SLEEPLESSNESS	YES	NO
DEPRESSION	YES	NO
CHANGE IN SENSATION	YES	NO
MEMORY LOSS	YES	NO
POOR COORDINATION	YES	NO
WEAKNESS OR PARALYSIS	YES	NO

Description of medical symptoms at this time

____

____

____

____

____

Name __________ Date __________ History No. __________