HEALTH QUESTIONNAIRE

NAME: _____ DOB: _____

Reason for your visit: _____DATE_____

How long have you had this problem? _____ Week(s) _____ Month(s) _____ Year(s)

Pharmacy name and address_____

PLEASE ANSWER *ALL* QUESTIONS ON EVERY PAGE – THANK YOU!

Have you been experiencing any of the following over the past 2 weeks?

(Check all that apply)

___Fever/chills or sweats
___Weight loss or gain
___Fatigue/tiredness
___Headaches
___Allergies/hay fever
___Eye/vision problems
___Ear/hearing problems
___Nose/nasal problems
___Postnasal drip
___Swollen glands
___Coughing spells
___Coughing up phlegm
___Coughing up blood
___Shortness of breath
___Wheezing
___Chest tightness
___Pain with breathing
___Snoring
___Calf or leg pain
___Chest pain/angina
___Dizzy spells
___Stomach trouble
___Indigestion
___Constipation/diarrhea
___Heartburn
___Ulcers
___Vomiting or nausea
___Dark or bloody stools
___Frequent urination
___Burning urination
___Easy bruising
___Aching muscles
___Anxious feelings
___Frequent thirst/hunger
___Blood in urine
___Other _____

Do you have a problem now or in the past with any of the following?

(Check all that apply)

___ Anemia
___ Arthritis
___ Asthma
___ Bone fractures
___ Bronchitis
___ Cancer
___ Depression
___ Diabetes
___ Emphysema
___ Gastric reflux
___ Gout
___ Hay fever
___ Heart attack/Angina
___ Heart disease
___ Heart murmur
___ Heart valve disease
___ High blood pressure
___ Irregular heartbeat
___ Kidney stones
___ Nervousness
___ Osteoporosis
___ Pneumonia
___ Phlebitis, blood clots
___ Prostate problems
___ Rashes
___ Rheumatic fever
___ Seizures
___ Sinusitis
___ Sleep problems
___ Stroke or TIA's
___ Thyroid problems
___ Ulcers
___ Urine infections

ALLERGIES

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list below:

Medicine: _____ Reaction: _____

Medicine: _____ Reaction: _____

Medicine: _____ Reaction: _____

Medicine: _____ Reaction: _____

Are you allergic to any foods, dyes, or other?

Please explain:

_____

_____

_____

IMMUNIZATIONS

Do you get the Influenza vaccine every year? ☐ YES ☐ NO Date last received: _____

Have you ever had the Pneumonia vaccine? ☐ YES ☐ NO Date last received: _____

Have you ever had the TB skin test? ☐ YES ☐ NO Date last received: _____

FAMILY HISTORY

	Age	Alive (yes or no)	Medical Problems	Cause of Death
Father:				
Mother:				
Sibling:				
Sibling:				
Sibling:				
Child:				
Child:				
Child:				

NAME: _____ DOB: _____

SOCIAL HISTORY

Birthplace: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Pets at home: □ NO □ YES _____

Alcohol use: Now? □ YES □ NO In the past? □ YES □ NO

How many drinks? ___ Day ___ Week ___ Month

Smoking: Now? □ YES □ NO In the past? □ YES □ NO

Age started _____ Age Quit _____ Packs per day _____

Any use of weight loss medications? _____

Occupation: _____

Have you ever been exposed to the following? Please check all that apply.

□ Asbestos □ Dust □ Metal □ Mining □ Wheat dust □ Chemicals

Have you ever had a positive TB skin test? □ YES □ NO

Have you ever been exposed to TB (tuberculosis)? □ YES □ NO

Where have you lived? _____

Have you traveled abroad? If so, where? _____

_____

MEDICATIONS

Please list ALL medications: Dose How often?

_____

_____

_____

(Additional lines next page)

NAME: _____ DOB: _____

SURGERIES

Year Where

HOSPITALIZATIONS

Year Where

MEDICAL PROBLEMS

NAME: _____ DOB: _____