



HEALTH QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

Who referred you to Dr. Bender? _____

Reason for visit: _____

Health History:

Please answer the following questions about your health. All answers are confidential.

When did you last visit a physician? _____ For what reason? _____

What is your approximate height: _____ weight: _____

Have you ever had any of the following problems or ailments with your **skin**? Yes___ No___

- rashes, hives
- skin cancer
- psoriasis
- other skin diseases/condition

If yes explain _____

Have you ever had any of the following problems or diseases of the **eyes**? Yes___ No___

- blurred or double vision
- glaucoma
- paralyzed/droopy eyelid
- other eye disease?

If yes explain _____

Have you ever had any of the following problems or diseases with your **ears, nose, sinuses, throat or lungs**? Yes___ No___

- hearing loss
- recurring sinus infections
- recurring sore throat
- prolonged productive cough
- prolonged hoarseness
- asthma
- emphysema
- recurring bronchitis or pneumonia
- shortness of breath
- other

If yes, explain _____

Have you ever had or been diagnosed with the following **bone, joint or muscular disorders**? Yes___ No___

- osteoarthritis
- rheumatoid arthritis
- joint replacement
- osteoporosis or osteopenia
- fibromyalgia
- other bone, joint or muscular disorder

If yes, explain _____

Have you ever had any of the following problems or diseases of the **stomach, intestines or liver**? Yes___ No___

- reflux(GERD)
- gastric ulcer syndrome
- colitis/Crohn's disease
- colon cancer
- liver disease/cirrhosis/IBS
- jaundice
- other

If yes, explain _____

Have you ever had any of the following problems with your **kidney, bladder, or urinary tract**? Yes___ No___

- frequent urination
- recurring kidney infection
- enlarged prostate
- kidney stones
- other

If yes, explain _____

Have you experienced or been treated or diagnosed with the following? Yes___ No___

- diabetes
- thyroid problems
- unexplained weight gain or loss
- taken weight loss medication

If yes, explain _____

Have you ever been treated for the following conditions? Yes___ No___

- stroke
- paralysis
- Bell's Palsy
- migraines
- seizures/convulsions
- fainting/dizziness
- Anxiety
- Depression
- ADD/ADHD

Have you ever had or been treated for any of the following conditions of the **heart or blood**? Yes___ No___

- | | | |
|--|---|--|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> “leaky” heart valve | <input type="checkbox"/> high cholesterol |
| <input type="checkbox"/> low blood pressure | <input type="checkbox"/> replaced heart valve | <input type="checkbox"/> anemia |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> rheumatic heart fever | <input type="checkbox"/> leukemia |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> congestive heart disease | <input type="checkbox"/> bleeding problems |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> heart surgery | <input type="checkbox"/> other heart or blood disorder |
| <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> irregular heart rate | |

Have you ever been diagnosed with the following **autoimmune diseases**? Yes___ No___

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Rheumatoid | <input type="checkbox"/> other |
| <input type="checkbox"/> Sjogren’s | |

Have you ever had or been treated for any of the following **infectious diseases**? Yes___ No___

- | | |
|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> HIV (AIDS) | <input type="checkbox"/> Syphilis |

Have you ever had cancer or a tumor? Yes No

If yes, explain _____

Have you ever received chemotherapy or radiation (x-ray) therapy? Yes No

Have you taken a steroid medication like prednisone in the past 2 years? Yes No

Females: Have you experienced changes in your menstrual cycle? Yes No

Are you pregnant? Yes No

Have you ever been in the hospital or had a surgical procedure? Yes No

If yes, list _____

Have you ever smoked or used tobacco? Yes No

Do you drink alcoholic beverages? Yes No

Have you ever had a drug or alcohol problem? Yes No

Have you ever abused narcotic pain medications? Yes No

Are you allergic or adverse reaction to any of the following? Yes___ No___

- | | | |
|---|--|--|
| <input type="checkbox"/> penicillin/amoxicillin | <input type="checkbox"/> other antibiotic | <input type="checkbox"/> codeine |
| <input type="checkbox"/> tetracycline | <input type="checkbox"/> latex | <input type="checkbox"/> sedatives or anesthesia |
| <input type="checkbox"/> sulfa | <input type="checkbox"/> dental anesthetic | <input type="checkbox"/> other |
| <input type="checkbox"/> erythromycin | <input type="checkbox"/> other dental material | |

Is there anything in your medical history that is not included in this questionnaire that you need to share with us? Yes No

Are there any pertinent health problems in your immediate family (e.g.: diabetes, cancer, heart disease, bleeding problems)?

Please list all medications you are currently taking _____

Do you take aspirin daily? Yes No

Do you take herbal supplements? Yes No Please specify _____

I understand the importance of a truthful health history and realize that an incomplete history may have an adverse effect on my treatment. To the best of my knowledge, I have completely and accurately reviewed my health history with Dr. Bender and confirm that I have accurately disclosed all past and present conditions.

_____ Date

_____ Signature of Patient/Guardian