



# UNIVERSITY HEALTH CENTER

## HEALTH QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

\* For the following conditions please check:  for **previously** had,  for **presently** have.

### General:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> <input type="radio"/> Alcoholism        | <input type="checkbox"/> <input type="radio"/> Gout                | <input type="checkbox"/> <input type="radio"/> Rheumatic fever      |
| <input type="checkbox"/> <input type="radio"/> Anemia            | <input type="checkbox"/> <input type="radio"/> Hypoglycemia        | <input type="checkbox"/> <input type="radio"/> Rheumatoid arthritis |
| <input type="checkbox"/> <input type="radio"/> Cancer            | <input type="checkbox"/> <input type="radio"/> Multiple sclerosis  | <input type="checkbox"/> <input type="radio"/> Depression           |
| <input type="checkbox"/> <input type="radio"/> High cholesterol  | <input type="checkbox"/> <input type="radio"/> Osteoarthritis      | <input type="checkbox"/> <input type="radio"/> Tuberculosis         |
| <input type="checkbox"/> <input type="radio"/> Diabetes          | <input type="checkbox"/> <input type="radio"/> Parkinson's disease | <input type="checkbox"/> <input type="radio"/> Ulcers               |
| <input type="checkbox"/> <input type="radio"/> Epilepsy/Seizures | <input type="checkbox"/> <input type="radio"/> Pneumonia           | <input type="checkbox"/> <input type="radio"/> Venereal Disease     |
| <input type="checkbox"/> <input type="radio"/> Thyroid           | <input type="checkbox"/> <input type="radio"/> Polio               | <input type="checkbox"/> <input type="radio"/> Skin Problems        |

### Resistance to infection:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> <input type="radio"/> Catch colds easily | <input type="checkbox"/> <input type="radio"/> Frequent sinus trouble | <input type="checkbox"/> <input type="radio"/> Frequent influenza |
|---|---|---|

### Gastrointestinal:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> <input type="radio"/> Gall bladder problem                            | <input type="checkbox"/> <input type="radio"/> Heartburn               | <input type="checkbox"/> <input type="radio"/> Mucus in stool     |
| <input type="checkbox"/> <input type="radio"/> Liver trouble/Hepatitis                         | <input type="checkbox"/> <input type="radio"/> Nausea                  | <input type="checkbox"/> <input type="radio"/> Colitis            |
| <input type="checkbox"/> <input type="radio"/> Excessive thirst                                | <input type="checkbox"/> <input type="radio"/> Diarrhea                | <input type="checkbox"/> <input type="radio"/> Hiatal hernia      |
| <input type="checkbox"/> <input type="radio"/> Distress from greasy foods                      | <input type="checkbox"/> <input type="radio"/> Blood in stool          | <input type="checkbox"/> <input type="radio"/> Vomiting           |
| <input type="checkbox"/> <input type="radio"/> Pain over Stomach                               | <input type="checkbox"/> <input type="radio"/> Metallic taste in mouth | <input type="checkbox"/> <input type="radio"/> Constipation       |
| <input type="checkbox"/> <input type="radio"/> Burning in stomach relieved by eating           |  | <input type="checkbox"/> <input type="radio"/> Recent weight gain |
| <input type="checkbox"/> <input type="radio"/> Burping or bloating (if bloating, where?) _____ |  | <input type="checkbox"/> <input type="radio"/> Recent weight loss |

### Cardiovascular:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> <input type="radio"/> Pain over heart    | <input type="checkbox"/> <input type="radio"/> Irregular heartbeat             | <input type="checkbox"/> <input type="radio"/> Low blood pressure  |
| <input type="checkbox"/> <input type="radio"/> Heart attack       | <input type="checkbox"/> <input type="radio"/> Stroke                          | <input type="checkbox"/> <input type="radio"/> High blood pressure |
| <input type="checkbox"/> <input type="radio"/> Swelling in ankles | <input type="checkbox"/> <input type="radio"/> Shortness of breath on exertion | <input type="checkbox"/> <input type="radio"/> Pressure over chest |

### Nervous System:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> <input type="radio"/> Dizziness/Lightheaded | <input type="checkbox"/> <input type="radio"/> Vision problems | <input type="checkbox"/> <input type="radio"/> Dental problems                   | <input type="checkbox"/> <input type="radio"/> Hoarseness  |
| <input type="checkbox"/> <input type="radio"/> Fainting              | <input type="checkbox"/> <input type="radio"/> Hearing loss    | <input type="checkbox"/> <input type="radio"/> Nose bleeds                       | <input type="checkbox"/> <input type="radio"/> Sore throat |
| <input type="checkbox"/> <input type="radio"/> Discoordination       | <input type="checkbox"/> <input type="radio"/> Ear pain        | <input type="checkbox"/> <input type="radio"/> Difficulty breathing through nose |  |

### Eye, Ear, Nose and Throat:

- Memory loss
- Ear noises
- Difficult speech

\* For the following conditions please check:  for **previously** had,  for **presently** have.

**Urinary Tract:**

- Blood in urine
- Inability to control urination
- Painful urination
- Bladder infection
- Kidney stones

**Respiratory:**

- Chest pain
- Coughing up blood
- Difficulty breathing
- Shortness of breath
- Allergies

- Chronic cough
- Spitting up phlegm
- Emphysema
- Asthma

**Women Only:**

- Irregular periods
- Hot flashes
- Vaginal discharge
- Menopausal symptoms
- Headaches with period
- Menstrual cramps
- Excessive flow
- Hysterectomy
- Premenstrual depression
- Painful breasts
- Lumps in breasts

**Men Only:**

- Burning on urination
- Prostate trouble
- Feeling of incomplete bowel evacuation
- Need to get up at night to urinate
- Difficulty starting urine
- Dripping after urination

**Blood Sugar:**

- Irritable before meals
- Get "shaky" if hungry
- "Lightheaded" if meals delayed
- Fatigue relieved by eating
- Heart palpitates if meals are missed/delayed
- Awaken after a few hours sleep, hard to get back to sleep
- Moods of depression - "blues" or melancholy
- Abnormal craving for sweets or snacks

**Neuromusculoskeletal**

- Headaches
- Upper extremity pain
- Neck pain
- Lower extremity pain
- Low back pain
- Tingling in hands or feet

**Please list all conditions that you are currently being treated for:**

Condition	Medications	Doctor	Date of Last Treatment

**Health Promotion Questions:**

1. How are you sleeping? \_\_\_\_\_

2. List any medications that you are taking: \_\_\_\_\_

3. List any dietary supplements (vitamins, herbs) that you are taking regularly: \_\_\_\_\_

\_\_\_\_\_

4. Are you following a special diet? \_\_\_\_\_

5. How many times a day do you usually eat? \_\_\_\_\_

6. What is your exercise program? \_\_\_\_\_

\_\_\_\_\_

7. Do you smoke? \_\_\_\_\_ Drink alcohol? \_\_\_\_\_

Have any other habits that affect your health? \_\_\_\_\_

8. Do you feel that you are under stress? \_\_\_\_\_

9. How would you describe your health in general?  Excellent  Good  Fair  Poor

Signature: \_\_\_\_\_ Date: \_\_\_\_\_