



Health Questionnaire Update

Chart # _____

Patient Name _____ Date _____

Please take a moment to review the questions below. Indicate whether you have been bothered by these complaints since your last visit to VCS.

CARDIOVASCULAR

- No Yes Severe chest pain
- Shortness of breath
- Irregular heart beat
- Fast heart beat
- Dizziness
- Blacking out
- Leg swelling
- Leg pain when walking

EYES

- No Yes New visual problems such as double vision or brief loss of vision in either eye

EARS/NOSE/MOUTH

- No Yes Nose bleeds
- Sinus infections

GASTROINTESTINAL

- No Yes Severe abdominal pains
- Persistent diarrhea
- Recurrent nausea
- Vomiting blood
- Rectal bleeding/blood in stool

GENITOURINARY

- No Yes Burning or painful urination
- Blood in urine

HEMATOLOGIC/LYMPHATIC

- No Yes Abnormal bleeding
- Swollen lymph nodes in neck, arm pits, or groin

RESPIRATORY

- No Yes Persistent cough
- Coughing up blood
- Wheezing

MUSCULOSKELETAL

- No Yes Severe back pain
- Joint pain

SKIN/BREAST

- No Yes Skin rash
- Skin sores

NEUROLOGICAL

- No Yes One-sided weakness
- Severe headaches
- Unstable gait

ENDOCRINE

- No Yes Excessive thirst
- Nocturnal urinations more than two times per night

CONSTITUTIONAL

- No Yes Recurrent fevers
- Shaking chills
- Unexplained weight loss greater than 10 pounds

Do you drink alcohol? No Yes If yes, estimate your weekly intake _____

Do you have or have you had cancer? No Yes If yes, when, and what type? _____

Do you use tobacco products? No Yes If yes, how much per day? _____

For how long? _____

If you quit, when? _____

Do you drink coffee, tea, or soda? No Yes If yes, how much per day? _____

Are you allergic to any medicines? No Yes If yes, which medicine(s)? _____

List ALL of your present medications (name, dosage, and schedule) _____

Patient Signature _____ Date _____

Physician Comments _____

Physician Signature _____ Date _____