CCBC - Health Questionnaire

Health Questionnaire

Patient Name:_____**DOB**:_____

Pharmacy Information:

Pharmacy Name: _____Pharmacy Phone #:_____

Pharmacy Address: _____

Primary Care Information:

Primary Care Physician: _____

Physician's Address: _____

Physician's Phone #:_____Fax #:_____

Weight Loss History (Please check the appropriate boxes and add notes as needed, please be specific)

- My obesity started: ☐ In Childhood ☐ At Puberty ☐ As an adult ☐ After Pregnancy
  ☐ After a traumatic event ☐ Other: _____
- Currently I am: ☐ Enrolled in a Gym ☐ Enrolled in a structured exercise program
  ☐ Other (i.e. yoga, swimming, walking, Zumba, etc.): _____

Weight Loss Programs/Diets/Medications: (Please list type and dates)

- Medically Supervised weight loss attempts:_____
  _____
- Weight Loss Programs:_____
  _____
- Diets:_____
  _____
  _____

Height:_____

Highest Adult Weight:_____Date:_____

Lowest Adult Weight:_____Date:_____

Most weight lost on any program:_____Program type:_____

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Taste Preferences (please check all that apply)

☐ Sweets ☐ Salty ☐ Fast Food ☐ Comfort Foods ☐ Other:_____

Eating Habits (please check all that apply)

☐ Binge Eater ☐ Stress ☐ Boredom ☐ Lonliness ☐ Other:_____

Other Habits

Are you a smoker? ☐ No ☐ Yes Packs/day:_____

Have you ever been a smoker? ☐ No ☐ Yes Age Started:_____ Year Quit:_____

Do you consume alcohol? ☐ No ☐ Yes Drinks/week:_____

Do you use recreational drugs? ☐ No ☐ Yes Type/frequency:_____

Do you use caffeine? ☐ No ☐ Yes Type/frequency:_____

Medications

Please list any medications to which you are allergic:

Medication	Reaction

Please list any medication, vitamins and/or herbal supplements you are presently taking:

Medication	Dosage	Frequency/ Time Taken

Please list all previous surgeries and/or hospitalizations:

Procedure/ Diagnosis	Date	Hospital/ Location

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Family History (Please check which, if any, of your family members had any of the following conditions):

Condition	Mother	Father	Brother	Sister	Comment
Anemia					
Bleeding Problems					
Blood Clots					
Cancer					
Diabetes					
Gallstones					
Gout					
Heart Disease					
High Blood Pressure					
Kidney Disease					
Obesity					
Sleep Apnea					
Stroke					

Obesity Related Conditions (Please check any following conditions that YOU have):

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Reflux/ Heartburn
- ☐ Hiatal hernia
- ☐ Arthritis/ Joint pain
- ☐ Rash
- ☐ Headaches
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ Coughing or choking at night
- ☐ Shortness of breath
- ☐ Day time falling asleep
- ☐ Leakage of urine
- ☐ Depression
- ☐ Swollen ankles/feet
- ☐ Heart attack
- ☐ Hernia

Other Health History

- If over the age of 50, have you ever had a colonoscopy?_____ If so, when?_____
- If over the age of 40 and female, have you ever had a mammogram? _____ If so, when? _____
- Have you recently had an EKG?_____ If so, when?_____
- Have you recently had a Chest X-Ray?_____ If so, when?_____

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Check Symptoms you currently have or have had in the past year.

General
- ☐ Unexplained Fevers
- ☐ Unexplained Change in Weight
- ☐ Depression
- ☐ Sweats
- ☐ Shortness of Breath
- ☐ Unusual Fatigue
- ☐ Headaches
- ☐ Change in Sleeping Habits
- ☐ Nervousness
- ☐ Dizziness
- ☐ Fainting

Eyes
- ☐ Wear Glasses or Contacts
- ☐ Recent Vision Changes
- ☐ Eye Surgery

Date of Last Eye Exam_____

- ☐ History of Glaucoma

Date of Last Test for Glaucoma If Over 50 Years of Age_____

- ☐ Vision- Flashes
- ☐ Vision- Halos
- ☐ Blurred Vision

Ears/Nose/Mouth/Throat
- ☐ Ear Infections
- ☐ Ear Discharge
- ☐ Earache
- ☐ Ringing in Ears
- ☐ Wear Hearing Aids
- ☐ Hearing Loss/Deafness
- ☐ Nosebleeds
- ☐ Sinus Problems
- ☐ Date of Last Dental Exam_____
- ☐ Wear Dentures
- ☐ Bleeding Gums
- ☐ Unusual Mouth Sores
- ☐ Difficulty Swallowing
- ☐ Persistent Cough

Endocrine
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Increase in Urinary Output
- ☐ Goiters

Respiratory
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ History of Pneumonia
- ☐ History of Tuberculosis
- ☐ Asthma
- ☐ Use a CPAP machine

Gastrointestinal
- ☐ Gallbladder Disease
- ☐ Burning
- ☐ Reflux
- ☐ Indigestion
- ☐ Nausea or Vomiting
- ☐ Change in Bowel Habits
- ☐ Change in Appetite
- ☐ Diarrhea
- ☐ Constipation
- ☐ Excessive Gas
- ☐ Hemorrhoids
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Ulcers
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease

Genitourinary
- ☐ Urination Frequency
- ☐ Painful Urination
- ☐ Increase or Decrease in ☐Output
- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ History of Prostate Problems
- ☐ History of Kidney Stones

Musculoskeletal
- ☐ Joint Swelling
- ☐ Fractures
- ☐ Muscle Pain
- ☐ Weakness
- ☐ Arthritis
- ☐ Numbness in Limbs
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Please Specifiy_____

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Itching
- ☐ Food Allergies

Skin
- ☐ Scarring
- ☐ Itching
- ☐ Hives
- ☐ Rash
- ☐ Sores That Won't Heal
- ☐ Change in Appearance of Moles
- ☐ Discolorations
- ☐ Lesions
- ☐ Skin Cancers

Psychiatric
- ☐ Hospitializations
- ☐ Treatment/ Counseling
- ☐ Depression
- ☐ Change in Sleep Habits
- ☐ Nervousness
- ☐ Anxiety
- ☐ Concentration Problems
- ☐ History of Suicide Attempts
- ☐ Substance Abuse Problems

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Rapid Heart Beat
- ☐ Heart Murmurs
- ☐ Poor Circulation

Neurologic
- ☐ Fainting
- ☐ Seizures
- ☐ Memory Loss
- ☐ Unusual or Unexplained Headaches
- ☐ Disorientation
- ☐ Changes in Speech
- ☐ Weakness
- ☐ Migraine Headaches

Hematologic/Lymphatic
- ☐ Bruises Easily
- ☐ History of Anemia
- ☐ Excessive Tiredness

Men Only
- ☐ Breast Lump
- ☐ Sore on Penis
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penile Discharge
- ☐ Other_____

Women Only
- ☐ Abnormal Pap Smear
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Nipple Discharge
- ☐ Other_____

Date of Last Menstrual Period_____

Date of Last Pap Smear_____

Are You Pregnant?_____

Number of Children_____