Dr. Eric Toder
- Health Questionnaire -

Patient's Name: _____ **Today's Date:** _____

Age: _____ **Race / Nationality:** _____

Occupation: _____ **Work Phone:** _____ **Home Phone:** _____

DRUG ALLERGIES / Reactions: _____

Current Medicines:

_____
_____
_____
_____
_____

Childhood Illnesses (Circle Y/N)

Measles ..... Y ..... N
Mumps ..... Y ..... N
Chicken Pox ..... Y ..... N
Rheumatic Fever ..... Y ..... N
Allergies ..... Y ..... N
Congenital Disease. ..... Y ..... N

Adult Illnesses (Circle Y/N)

Diabetes ..... Y ..... N
Tuberculosis ..... Y ..... N
Cancer ..... Y ..... N
Hypertension ..... Y ..... N
Heart Attack ..... Y ..... N
Stroke ..... Y ..... N

Have you ever had any serious illnesses or trauma? If yes, please list: _____

_____

Have you ever been hospitalized? If yes, for what reason: _____

_____

Surgeries: Please list all your surgeries: _____

Family history:	If Living: Age?	If Deceased: Age at Death?	Please Circle State of Health	Major health problem(s) or cause of death?
Father			Good / Poor	
Mother			Good / Poor	
Brother / Sister			Good / Poor	
Spouse			Good / Poor	
Son(s)			Good / Poor	
Daughter(s)			Good / Poor	

Lifestyle History:

Do you now or have you ever had a Substance abuse Problem? ..... Y ..... N
Have you been Medically Treated for Substance abuse? ..... Y ..... N
Do you smoke? ..... Y.....N
Do you drink alcohol? ..... Y ..... N
Do you exercise regularly? ..... Y ..... N
Are you currently under high stress? ..... Y ..... N

Do you have any allergies or food sensitivities? ..... Y ..... N
If so, please list: _____

_____

If yes, What and How much? _____
If yes, How much and What? _____
If, yes What type and How Frequently? _____
If yes, Please list the stress source: _____

What vitamins or herbs do you take, If any? _____

What medical tests have you had in the last year? _____

Please list hobbies? _____

Neurological
Headaches ..... Y ..... N
Dizziness ..... Y ..... N
Blackouts ..... Y ..... N
Stroke ..... Y ..... N
Paralysis / Weakness ..... Y ..... N
Head Trauma ..... Y ..... N
Loss of Consciousness ..... Y ..... N
Seizures ..... Y ..... N
Tremors. ..... Y ..... N
Memory Loss ..... Y ..... N

Eyes
Double Vision ..... Y ..... N
Blindness ..... Y ..... N
Blurred Vision. ..... Y ..... N
Cataracts ..... Y ..... N
Glaucoma ..... Y ..... N
Eye Injury ..... Y ..... N

Ears
Decreased Hearing ..... Y ..... N
Ringing in Ears ..... Y ..... N
Ear Injury ..... Y ..... N

Nose
Stuffy Nose ..... Y ..... N
Runny Nose ..... Y ..... N
Nose Bleeds ..... Y ..... N
Sinusitis ..... Y ..... N

Throat
Postnasal Drip ..... Y ..... N
Frequent Sore Throats ..... Y ..... N
Hoarseness ..... Y ..... N
Enlarged Gland ..... Y ..... N

Lungs
Frequent Cough ..... Y ..... N
Wheezing ..... Y ..... N
Asthma ..... Y ..... N
Shortness of Breath ..... Y ..... N
On Exertion ..... Y ..... N
When Resting ..... Y ..... N
Coughing Up Blood ..... Y ..... N
Bronchitis ..... Y ..... N
Pneumonia ..... Y ..... N
Pleuritis ..... Y ..... N
Emphysema / COPD ..... Y ..... N
Tuberculosis ..... Y ..... N

Immune System
How Many times per year do
you get a cold or the Flu _____

Are you always tired ..... Y ..... N
Any changes in your
general health ..... Y ..... N

Cardiovascular
High Blood Pressure ..... Y ..... N
Palpitations / Fluttering ..... Y ..... N
Chest Pain or Angina ..... Y ..... N
Difficulty Breathing
when lying down. ..... Y ..... N
Swelling of Hands or Feet ..... Y ..... N
Heart Attack ..... Y ..... N
Heart Failure ..... Y ..... N
Heart Murmur ..... Y ..... N

Vascular
Varicose Veins ..... Y ..... N
Leg cramps with walking ..... Y ..... N
Plebitis or Blood Clots ..... Y ..... N

Stomach & Bowel
Weight Gain ..... ____lbs. Y ..... N
Weight Loss ..... ____lbs. Y ..... N
Appetite - Increased ..... Y ..... N
Appetite - Decreased ..... Y ..... N
Nausea ..... Y ..... N
Vomiting ..... Y ..... N
Chronic Diarrhea ..... Y ..... N
Chronic Constipation ..... Y ..... N
Ulcers ..... Y ..... N
Abdominal Cramps ..... Y ..... N
Hemorrhoids ..... Y ..... N
Liver Disease ..... Y ..... N
Hepatitis ..... Y ..... N
Gallbladder Disease ..... Y ..... N
Vomiting Blood ..... Y ..... N
Blood in Stool ..... Y ..... N
Black Tarry Stool ..... Y ..... N
Gastric reflux / Heartburn ..... Y ..... N

Kidney & Bladder
Frequent Urination ..... Y ..... N
Kidney Problems ..... Y ..... N
Pain With Urination ..... Y ..... N
Blood in the Urine ..... Y ..... N
Loss of Control of Urination ..... Y ..... N
Kidney Stones ..... Y ..... N
Bladder Infection (UTI) ..... Y ..... N
Kidney Infections ..... Y ..... N

Musculoskeletal
Any pain in your -
Neck ..... Y ..... N
Upper Back ..... Y ..... N
Lower Back ..... Y ..... N
Tailbone ..... Y ..... N
History of disk Problems ..... Y ..... N
Pain or Numbness in your -
Hands or Arms ..... Y ..... N
Legs ..... Y ..... N
Broken or Cracked Bones ..... Y ..... N
History of Temporomandibular
joint Problems ..... Y ..... N
Arthritis, Gout, or Joint Pain ..... Y ..... N
Carpal Tunnel ..... Y ..... N

Skin
Rashes ..... Y ..... N
Changes in Moles ..... Y ..... N
Warts ..... Y ..... N
Herpes ..... Y ..... N

Sleep
Sleepiness during the day..... Y ..... N
Daytime Naps ..... Y ..... N
Trouble Falling Asleep ..... Y ..... N
Snoring ..... Y ..... N
Jerking or Kicks while asleep ... Y ..... N
Sleep apnea.....Y..... N

Psychological
Depression, Anxiety or
Psychosis ..... Circle one

Endocrine
Thyroid Disease ..... Y ..... N
Increased Thirst, Hunger or
Urination ..... Y ..... N
Diabetes ..... Y ..... N
Hormonal Treatment ..... Y ..... N
Type _____

Hematology
Cancer ..... Y ..... N
History of Anemia ..... Y ..... N
Easily Bruised ..... Y ..... N
Night Sweats ..... Y ..... N
Blood Transfusions ..... Y ..... N

FOR MEN ONLY
Prostate Problems ..... Y ..... N
Difficulty Emptying out Bladder .. Y ..... N
Weak Urine Stream ..... Y ..... N
Erection Difficulties ..... Y ..... N
Night Time Urination ..... Y ..... N

FOR WOMEN ONLY
Do you take Birth Control Pills ... Y ..... N
Do you have hot flashes ..... Y ..... N
# of Pregnancies ..... _____
# of Children ..... _____
# of Miscarriages /
Abortions ..... _____
Breast Pain or tenderness ..... Y ..... N
Breast Masses or
Lumps ..... Y ..... N
Drainage from the breast ..... Y ..... N

Menstrual History
Age your period started ..... Y ..... N
How long does it last ..... ____days
Is Your Flow -
Light, Medium, or Heavy ..... Circle one
Is there Pain or clots ..... Y ..... N
Date of Last Period ..../...../ .....
Date of Last Pap ...../...../ .....
Vaginal Itching ..... Y ..... N
Vaginal Discharge ..... Y ..... N
Vaginal Infection ..... Y ..... N
Endometriosis ..... Y ..... N