C. Raghavan. M.D.
Confidential Health Questionnaire

Name: _____ DOB: _____ Date: _____

Allergies

Medicines: _____
Anesthesia: _____
Insect bite: _____
Foods: _____

Habits	How much?	How often?
Smoker	_____	_____
Alcohol	_____	_____
Chew Tobacco	_____	_____
Tea/Coffee	_____	_____
Exercise	_____	_____

Social

☐ Single ☐ Married ☐ Separated ☐ Divorced

Number of Children: _____

Occupation: _____

Family (Check that those apply):

Mother, father, brother or sister ever had:

- ☐ Asthma
- ☐ Diabetes
- ☐ Cancer
- ☐ Blood Disease
- ☐ Glaucoma
- ☐ Epilepsy
- ☐ Arthritis
- ☐ Alcoholism
- ☐ Tuberculosis
- ☐ Gout
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Mental Disorder
- ☐ Suicide
- ☐ Stroke
- ☐ Rheumatic Fever

Surgery (List operations)

_____

_____

_____

Immunizations

Last Tetanus shot: _____

Last Tuberculosis skin test: _____

Last Flu shot: _____

Ever had Tuberculosis shot (BCG)? ☐ Y ☐ N

Pneumonia vaccine (Pneumovax)? ☐ Y ☐ N

Hospitalizations

Condition	Where?	Date

Have you had any of these problems?

- ☐ Eye Problems
- ☐ Ear Problems
- ☐ Thyroid Disease
- ☐ Strep Throat
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Stomach Ulcers
- ☐ Diverticulosis
- ☐ Hepatitis
- ☐ Measles
- ☐ Polio
- ☐ Chicken Pox
- ☐ Skin Disease
- ☐ General Herpes
- ☐ Gallbladder Trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Kidney Disease
- ☐ Prostate Disease
- ☐ Mental Problems
- ☐ Head Injury
- ☐ Stroke
- ☐ Seizures
- ☐ Gout
- ☐ Cancer
- ☐ Bleeding Disorder
- ☐ Diabetes
- ☐ German Measles
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Venereal Disease
- ☐ Oral Herpes

Females Only

Menstrual Period: ☐ Regular ☐ Irregular

Flow: ☐ Small ☐ Moderate ☐ Heavy

Pregnancies: Number _____

Abortions _____ Stillbirths _____ Living _____

Do you use birth control pills? ☐ Yes ☐ No

Do you practice self breast exams? ☐ Yes ☐ No

When do you do your self breast exams?

_____

Date of last Pap smear? _____

General comments or explanations

_____

_____

_____