HEALTH ASSESSMENT QUESTIONAIRE

Name: _____ Date of Birth: _____

Occupation: _____ Today's Date: _____

Past Medical Problems (operations, illnesses, injuries)

Year	Problem	Hospital

Present or Recurrent Medical Problems

Year	Problem

Medications

Name	Dose	Frequency

Allergies to Medications

Medication	Reaction

Family History

Relationship	Age if Living	Age at Death	State of Health or Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			
Child			
Child			
Child			
Child			
Child			

Illness	Family member w/ illness	Age at Onset
Breast Cancer		
Colon Cancer		
Prostate Cancer		
High Blood Pressure		
Coronary Artery Disease		
Diabetes		

Health Habits

Habits	Yes/No	How much/What kind
Tobacco		
Alcohol		
Caffeine		
Drugs		
Exercise		

Beauty Swe, M.D. · 301 S. Fair Oaks Avenue Suite 203 Pasadena, CA 91105 · Tel: (626) 356-4000 · Fax: (626) 799-4001

Health Screening

Test	Yes/No	Date	Any abnormalities
Mammogram			
Sigmoidoscopy			
Cholesterol			
Pap Smear			
Prostate Blood Test			
Prostate Physical Exam			
Bone Density			
Colonoscopy			

Other Doctors

Specialty	Doctor's Name	Phone #
Eye		
Heart		
Lung		
Urology		
Ob-Gyn		
Orthopedic		
Skin		
Other		

Use this space to note other conditions:

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