KENNETH D. DANYLCHUK, MD, PC

CONFIDENTIAL HEALTH QUESTIONNAIRE

Med. Rec. No.

Date:

Name _____

Address _____

_____ Date _____

Home Telephone _____

Business Telephone _____ Ext _____

Date of Birth _____ _____ Male _____ Female

_____ Married _____ Separated _____ Divorced _____ Widowed _____ Single

Occupation _____

Previous Occupations _____

Circle highest year reached in school:

(1-2-3-4-5-6-7-8) Elementary (1-2-3-4) High (1-2-3-4) College _____ Post Graduate

ILLNESSES

Place an (X) in the appropriate column for any illness that you have now or have had:

	NO	YES NOW	IN THE PAST
1. Diabetes	☐	☐	☐
2. Stroke	☐	☐	☐
3. Heart trouble	☐	☐	☐
4. High blood pressure	☐	☐	☐
5. TB	☐	☐	☐
6. Epilepsy	☐	☐	☐
7. Kidney disease	☐	☐	☐
8. Cancer	☐	☐	☐
9. Bleeding Disease	☐	☐	☐
10. Allergies and Asthma	☐	☐	☐
11. Ulcer	☐	☐	☐
12. Anemia	☐	☐	☐
13. Glaucoma	☐	☐	☐
14. Gout	☐	☐	☐
15. Nervous breakdown	☐	☐	☐
16. Rheumatism or arthritis	☐	☐	☐
17. Rheumatic fever	☐	☐	☐

IMMUNIZATIONS AND TESTS

	NO	YES	UNKNOWN
Have you had small pox vaccination the last five years?	☐	☐	☐
Have you had Tetanus vaccine in the past?			
How many years ago was the last booster? _____			
Have you had any of the following vaccines?			
(a.) Diptheria	☐	☐	☐
(b.) Polio	☐	☐	☐
(c.) Measles	☐	☐	☐
(d.) German Measles (Rubella)	☐	☐	☐
(e.) Mumps	☐	☐	☐
(f.) Tuberculin Test	☐	☐	☐
Positive	☐	☐	☐

MEDICINES (current)	Drug Allergies
1)	1)
2)	2)
3)	3)
4)	4)
5)	5)

HABITS

Tobacco has been used for _____ years.

I've never regularly used tobaco ☐

CIGARETTES

less than 1 package daily _____

1-2 packages daily _____

More than 2 daily

I discontinued use of tobacco

_____ (weeks, months, years) ago.

ALCOHOL

Would you charactarize your drinking as:

social ☐

occasional ☐

week-end ☐

daily

I discontinued use of alcohol

_____ (weeks, months, years) ago

Have you ever been turned down for life insurance, military service or employment because of health problems? ..... ___ Yes ____ No

Are you currently on disability _____ partial? _____ complete?; Medically retired _____ Yes _____ No.

HOSPITALIZATION	ONE	TWO	THREE	FOUR	FIVE	SIX
Type of operation, illness or injury						
Month and year hospitalized						
Name of hospital:						
City and State						

FAMILY HISTORY		General Health: Good	General Health: Poor	If deceased, Cause of Death	Allergies or Asthma	Anemia	Bleeding Tendencies	Cancer or Tumor	Diabetes	Epilepsy	Glaucoma	Gaut	Heart Trouble	High Blood Pressure	Kidney or Bladder Trouble	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Duodenal Ulcer	Stroke	Tuberculosis
Place an (X) in any box that applies:	Age																			
Father:																				
Mother:																				
Brothers or Sisters																				
Aunts & Uncles (Mark an (X) for illnesses only)																				
Grandparents (Mark an (X) for illnesses only)																				

WOMEN ONLY

Pregnancies _____

No. of Children _____

Miscarriages _____

Stillbirths _____

Mentrual History:

1st Mens. Period (age)_____

Last Mens Period _____

Cycle (days between)_____

Duration (in days)_____

Menapause (age)_____