SOUTH BAY MEDICAL WEIGHT LOSS CLINIC, INC

DRS. ASIF AZIMI, MD AND CLAUDIA KWON, MD

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HEALTH QUESTIONNAIRE

NAME: _____ AGE: _____ DATE: _____

ADDRESS: _____ PHONE: _____

HISTORY OF PAST ILLNESS: Have you had?

Childhood:

Measles..... Yes No
Mumps..... Yes No
Chickenpox..... Yes No
Diabetes.....Yes No
Strokes..... Yes No
Cancer..... Yes No
Tuberculosis..... Yes No
Venereal Disease..... Yes No
Rheumatic Fever or Heart Disease.....Yes No
Congenital Abnormalities..... Yes No
Other Serious Diseases.....Yes No
_____

Adult:

Have you had any serious illness?.....Yes No
Have you ever been hospitalized or been under medical care for very long? .....Yes No
If yes, for what reason? _____

Operations:

Have you had any surgery?.....Yes No
If yes, please list/year: _____
_____

Injuries:

Have you had any broken bones?.....Yes No
Have you had any head concussions or injuries?.....Yes No
Have you ever been knocked unconscious?.....Yes No

FAMILY HISTORY:	IF LIVING: AGE AND HEALTH	IF DECEASED: AGE (AT DEATH) & CAUSE	HAS ANY BLOOD RELATIVE EVER HAD:	
Father			Cancer	Yes No
Mother			Tuberculosis	Yes No
Brother/Sister			Diabetes	Yes No
			Heart Trouble	Yes No
			High Blood Pressure	Yes No
			Stroke	Yes No
Husband/Wife			Convulsions	Yes No
Son/Daughter			Suicide	Yes No
			Mental Illness	Yes No
			Bleeding Tendency	Yes No
			Gout or Other Arthritis	Yes No
			Hereditary Defects	Yes No

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed

Are you living with your husband or wife?.....Yes No
Do you have dependents at home?.....Yes No
Alcoholic Beverages: Never Rarely Moderately Daily Ever .....Yes No
Tobacco: Cigarettes Packs a Day Don't Smoke Ever Smoked…….....Yes No
Are you employed? _____ Full Time _____ Part Time
What is your job? _____
Are you exposed to fumes, dusts, or solvents? _____
How much time have you lost from work because of your health during the past? Six Months _____ One Year _____ Five Years _____
Education: (Years)
Grade School _____ College _____ Postgraduate _____

SYSTEMIC REVIEW: Do you have any of the following?

General:

Recent weight change?.....Yes No
Have you been in good general health most of your life?.....Yes No

Skin:

Skin disease.....Yes No
Jaundice.....Yes No
Hives, eczema, or rash.....Yes No
Frequent infection or boils.....Yes No
Abnormal pigmentation.....Yes No

Head· Eyes· Ears· Nose·Throat:

Eye disease or injury.....Yes No
Do you wear glasses?.....Yes No
Double vision.....Yes No
Headaches.....Yes No
Glaucoma.....Yes No
Itching eyes or nose.....Yes No
Sneezing or runny nose.....Yes No
Nosebleeds.....Yes No
Chronic sinus trouble.....Yes No
Ear disease.....Yes No

Impaired hearing..... Yes No
Dizziness or transient episodes of unconsciousness..... Yes No

Neck:
Stiffness..... Yes No
Thyroid problems..... Yes No
Enlarged glands..... Yes No

Respiratory:
URI (cold) now..... Yes No
Spitting up blood..... Yes No
Chronic or frequent cough..... Yes No
Asthma or Wheezing..... Yes No
Difficulty breathing..... Yes No
Any trouble with lungs..... Yes No
Pneumonia……..... Yes No

Cardiovascular:
Chest pain or angina pectoris..... Yes No
Shortness of breath with walking or lying down..... Yes No
Difficulty walking two blocks..... Yes No
Heart trouble or heart attacks..... Yes No
High blood pressure..... Yes No
Swelling of hands, feet, or ankles..... Yes No
Awakening in the night suffocating..... Yes No
Heart murmur..... Yes No

Gastrointestinal:
Peptic ulcer (stomach or duodenal)..... Yes No
Vomiting blood or food..... Yes No
Gallbladder disease..... Yes No
Liver trouble..... Yes No
Hepatitis..... Yes No
Painful bowel movements..... Yes No
Bleeding with bowel movements..... Yes No
Black stools..... Yes No
Hemorrhoids or piles..... Yes No
Recent change in bowel habits..... Yes No
Frequent diarrhea..... Yes No
Heartburn or indigestion..... Yes No
Cramping or pain in the abdomen..... Yes No
Does food stick in throat?..... Yes No

Genitourinary:
Loss of urine..... Yes No
Frequent urination..... Yes No
Night time urinating..... Yes No
Burning or painful urination..... Yes No
Blood in urine..... Yes No
Kidney problems..... Yes No
Kidney stones..... Yes No
Nephritis……..... Yes No

Gynecological:
Age periods started _____
How long do periods last? _____Days
Number of pregnancies _____
Number of miscarriages _____
Date of last Pap smear and results_____
_____
Frequency of periods, every _____ Days
Any pain with your periods..... Yes No
Number of children _____ Ages _____
Date of first day of last period_____

Locomotor· Musculoskeletal:
Varicose veins..... Yes No
Weakness of muscles or joints..... Yes No
Any difficulty in walking..... Yes No
Any pain in calves or buttocks on walking relieved by rest..... Yes No

Neuro· Psychiatric:
Have you ever had psychiatric care?..... Yes No
Have you been advised to see a psychiatrist?..... Yes No
Do you ever have, or have had, fainting spells?..... Yes No
Convulsions..... Yes No
Paralysis..... Yes No

Hematologic:
Are you slow to heal after cuts?..... Yes No
Blood disease..... Yes No
Anemia ..... Yes No
Phlebitis..... Yes No
Have you had difficulty with bleeding excessively after tooth extraction or surgery?..... Yes No
Have you had abnormal bruising or bleeding?..... Yes No

Allergic:
Any allergies, including medication..... Yes No

Endocrine:
Thyroid disease..... Yes No
Hormone therapy..... Yes No
Any change in hat or glove size..... Yes No
Any change in hair growth..... Yes No
Have you become colder than before or skin become dryer?..... Yes No

HEIGHT: _____
WEIGHT: _____

ALLERGIES AND SENSITIVITIES:

1. Is there a history of skin reaction or other untoward reaction of sickness following injection or oral administration of?

	Circle One			What Drug or Food?
Penicillin or other antibiotics.....	Yes	No	Don't Know	_____
Morphine, Codeine, Demerol or other narcotics.....	Yes	No	Don't Know	_____
Novocain or other anesthetics.....	Yes	No	Don't Know	_____
Aspirin or other pain remedies…….....	Yes	No	Don't Know	_____
Sulfa Drugs.....	Yes	No	Don't Know	_____
Tetanus antitoxin or other serums.....	Yes	No	Don't Know	_____
Adhesive tape.....	Yes	No	Don't Know	_____
Iodine or Merthiolate.....	Yes	No	Don't Know	_____
Any other drug or medication.....	Yes	No	Don't Know	_____
Any foods: such as egg, milk or chocolate.....	Yes	No	Don't Know	_____

2. Drugs recently taken, within the past six months:

Cortisone.....	Yes	No	Don't Know
ACTH.....	Yes	No	Don't Know
Anticoagulants.....	Yes	No	Don't Know
Tranquilizers.....	Yes	No	Don't Know
Hypotensives (high blood pressure medicines).....	Yes	No	Don't Know
Has the patient ever received treatment for:			
Asthma, rheumatism or rheumatic fever?.....	Yes	No	Don't Know
Aspirin.....	Yes	No	Don't Know

Name & Title:	**Date/Time:**	**Patient's Name/Signature:**
***Asif Azimi, MD** ***Claudia Kwon, MD**		