HEALTH QUESTIONAIRE

LAWRENCE F. RAHALL D.O. P.C.
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724-758-3393

Date______________________ Social Security #___________________________________

Name				Home Phone	
Date of Birth	Age	Sex M F	Marital Status S M W D	Work Phone	
Address ______________ City State ZIP				# of years you have owned your home_____ Own______________ Rent______________	
Employer		Occupation		Work phone	
In case of emergency notify		Phone		Relationship	
Why did you choose this office?				Who referred you?	

Have you ever been a patient here before? ___________________ Have you filled out a questionnaire before?____________________

List injuries, operations, and hospitalizations	Month/Year	Doctor

List any medications you are presently taking (including dosage/times per day)	**Dosage**	**Times per day**

List any allergies or sensitivities to medications, or latex	
Name	Reaction (describe)

Please answer all questions to the best of your ability

Yes	**No**	**Occasionally**	
			Have you been in poor health during the past year?
			Has your weight changed more than 10 lbs. in the past year? Current weight________ height __________
			Any skin problems? ___________________________ Unusual sores? ______________________________
			Any swollen glands? __________________________ Unusual lumps? ______________________________
			Any double vision? ___________________________ Recent change in eyesight? ____________________
			Any ringing in your ears? _____________________ Recent change in hearing? _____________________
			Frequent nasal congestion? ________________________ Nose bleeds? ___________________________
			Any problems with your teeth? _____________________ Gums? _________________________________
			Frequent sore throats? ________________________ Persistent hoarseness? _________________________
			Any sinus trouble? _______________________________
			Frequent coughing? ___________________________ Wheezing? __________________________________
			Have you ever coughed up blood? __________________________________
			Have you ever been exposed to someone with TB?
			Have you ever had trouble with unusual shortness of breath?
			Do you sleep on more than two pillows at night?
			Do you get short of breath at night?
			Do you legs and/or ankles swell? _________________ Do you get pain in your legs when you walk?____________
			Does your heart frequently race? ___________________ or skip beats? _________________________
			Do you get pain, tightness, or heaviness in your chest?
			Frequent stomach or abdominal pain?
			Frequent constipation? __________________________ Diarrhea? ________________________
			Any recent change in bowel habits?

			Frequent nausea? _________________________ Vomiting? __________________________
			Any pain, burning with urination? ________________Do you get up at night to urinate? __________________
			Any change in frequency? ______________________ Amount of urine? _________________________
			Any Redness, pain, or swelling in your joints?
			Any Severe back pain?
			Any recent changes to your hair, skin, or nails?
			Do you get frequent or severe headaches?
			Any fainting spells, loss of consciousness, or seizures?
			Any shakes? _________________________________ Tremors? ________________________________
			Any paralysis? ____________________________ Weakness of arms or legs? _____________________
			Any loss of sensation, numbness, or tingling?
			Any dizziness, or loss of balance?_____________________ Difficulty walking? ___________________

For Men Only

			Have you ever had any prostate trouble?
			Any sores? ___________________________ Discharge from penis? _______________________________
			Have you ever had any lumps? __________________ Infections of the testicles? ___________________

For women Only

			Do you have any problems with you menstrual periods?
			Any complications with pregnancies?
			Any vaginal bleeding between periods?
			Last Pap smear?
			Age periods began?____________________________ Age periods stopped? _________________________
			Number of pregnancies? _________________ Number of Miscarriages or abortions? ________________

Please list any additional problems you would like to discuss with the doctor____

____

Previous family Physician?. ____

Other Physicians you have seen in the past 5 years ____

____

____

Date last seen by a Physician ____

Have you ever been seen by a psychiatrist? ___________________________ If yes when? _______________________________________

Have you ever had an injury that was work related? ______________________ If yes please explain. ___________________________

____

Are you sexually active with more than one partner?____________________

Dou smoke cigarettes? Y N Pipe? Y N Cigar ? Y N

How many cigarettes do you smoke each day? _________________________ How many years have you smoked? ________________

Most frequent brand? ________________________________ Have you considered quitting? ____________________________________

Do you chew tobacco? _____________________ Snuff? _________________ What brand? ____________________________________

Do you use seatbelts? ______________ Always __________ Occasionally ______________ Never ___________________

What is your alcoholic intake per week? ____

Do you have a living will or Advance Directive? (if yes, we need to have a copy on file in the office)__________________________

Check the correct box if you or any blood relative has had any of the following problems (Mother, Father, Sister, Brother, Aunt, or Uncle)

Disease	Myself (age diagnosed)	Blood relative (Relationship/Age)
Leukemia		
Lung infection		
Bronchitis		
Tuberculosis		
Asthma		
Diabetes		
High Blood Pressure		
Heart Disease		
Stroke		
Cancer (Type and location)		
Ulcers		
Arthritis		

Check if you have had or been immunized or vaccinated

_____ Measles Date ____________
_____ German Measles(Rubella) Date ____________
_____Chicken Pox Date ____________
_____ Whooping cough Date ____________
_____ Mumps Date ____________
_____ Polio Date ____________
_____ Tetanus Date ____________
_____ Hepatitis A Date ____________
_____ Hepatitis B Date ____________
_____ Pneumovax Date ____________

I declare that my answers to the above questions are true and accurate to the best of my knowledge?

____ ________________________

Signature **Date**

Insurance and financial information (Please Print)

Name____ DOB _______________ Age ___________ Sex ______________

Address ____ City _____________________________ State _______ Zip __________

Health Insurance (Primary)

Insured Name____ Date of birth ________________

Insurance Company____

Policy # _________________________________ ID # _____________________________________ Group# ________________________

Employed? Y N Full time? ________ Part time? _________ Employer Name ____

Employer Address ____

Health Insurance (Secondary insurance)

Insured Name____ Date of birth _____________________

Insurance Company____

Policy # _________________________________ ID # _____________________________________ Group# ________________________

Employed? Y N Fulltime? ________ Part time? _________ Employer Name ____

Employer Address ____

Medicare

Medicare ID # (exact number on medicare card) ____ DOB _______________________

Basis for Medicare coverage: Age ________ Disability ____________

Workers Compensation Insurance

Date of Accident _________________ Type of Injury _______________________

Is the patient working? Y N Full time? __________ Part Time? _____________

Employer Name ____

Employer Address ____

Accident (Automobile or other)

Type of accident ____ Date of Accident ________________

Name of policy holder ____

Address of policy holder____

Name of Insurance Company ____

Name of Agent ____ Phone ____

Address of Agent ____

List immediate family members and dates of birth

____ ____

____ ____

Signature on File of the parent or legal guardian who accepts financial responsibility for the above family members:

____ ______________________________

Signature **Date**

Signature on File (Medicare or Insured)

I request that payment of authorized benefits be made on my behalf directly to Lawrence F. Rahall D. O. P. C. for any services furnished to me by that Physician/Clinic/Supplier. I also release to the Health Care Financing Administration and it's agents or insurance carrier, any information to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

____ ___________________________

Signature (medicare or insured) **Date**