Kantam L. Gade, MD
Spruce Multispecialty Group
1275 E. Spruce, Ste. 101
Fresno, CA 93720
(559) 439 – 5757

HEALTH QUESTIONAIRE
Personal Information

Date _____

Name _____ Age _____ Sex M F

Place of Birth _____ Marital Status m s d w

Occupation _____ Ethnic Background _____

MEDICAL INFORMATION

Do you have any current or past medical conditions? (please circle all that apply)

Seizures	High blood pressure	*Neurological disorders	Migraines
Stroke	Diabetes	Glaucoma	Heart attack
Osteoporosis	Deafness	Heart failure	Arthritis
*Thyroid disease	*Irregular heart beat	*Bone deformities/fractures	*Kidney disease
Seasonal allergies	Chest Pain	Chronic back pain	Ulcers
Asthma/Emphysema	High cholesterol	*Intestinal disease	*Genital disease
Tuberculosis	C O P D	Incontinence	Valley fever
Hepatitis	*Liver disease	*Cancer	

Other _____

_____

Please clarify any answers circled that have an * _____

_____

_____

List any surgeries or hospitalizations for illness/injury

1) _____ 2) _____

3) _____ 4)_____

5) _____ 6) _____

List any medication/food allergies 1) _____ 2) _____

3) _____ 4) _____ 5) _____

List all current medications:

Medication	Dose	Frequency	Medication	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Habits (circle any that apply)

		Amount/Frequency			Amount/Frequency			Amount/Frequency
Coffee	Y N	_____	Tobacco	Y N	_____	Exercise	Y N	_____
Drugs	Y N	_____	Alcohol	Y N	_____			
Smoke Cigarettes	Y N	_____	Tea	Y N	_____			

Family History (circle all that apply)

Thyroid disease	High Cholesterol	Obesity	Cancer: Specify
Asthma / Emphysema	Diabetes	Alzheimer's	Colon
Tuberculosis	Valley fever	Schizophrenia	Prostate
High blood pressure	Stroke	Osteoporosis	Breast
Heart disease	Kidney disease	Liver disease	Uterine
Other _____			Other cancer_____

_____

Are you currently experiencing any of the following (circle all that apply)

Weight gain/loss	Congestion	Urinary difficulty	Fevers
Chills	Difficulty breathing	Painful urination	Chest pain/pressure
Joint pain	Sweating	Headaches	Palpitations
Muscle aches	Change in vision	Heartburn	New moles
Leg/arm swelling	Skin growth	Decreased hearing	Abdominal pain
Rash	Dizziness	Constipation	Itching
Weakness	Diarrhea	Lumps	Cough
Bloody or black stool	Bleeding		

Other _____

_____

Please list any physicians who care/cared for you

1)_____2)_____3)_____

Females only:

Date of last menstrual cycle _____ Are you post-menopausal ? Y N

Do you or have you taken birth control pills or hormones? Y N

Did your mother or grandmother: Walk bent over? Fracture a hip? Get shorter with age?

Note:

1) Do you have any driving problems with your automobile? Y N
2) Were you treated or do you consider yourself dependent on alcohol or drugs? Y N
3) Do you have any special concerns/desires in end of life care? Y N
4) Do you have any personal or social or economic problems which will significantly affect your health? Y N

Kantam L. Gade, MD