OAKWOOD UNIVERSITY CHURCH HEALTH SERVICE

Name: _____
Date: _____

## HEALTH QUESTIONNAIRE

Do you have now or have you had persistent problems with the following?

**SKIN:**
- Rashes • Yes • No
- Hair or Nails • Yes • No

**HEAD:**
- Headache • Yes • No
- Head Injury • Yes • No
- Blackouts • Yes • No
- Dizziness • Yes • No
- Memory Loss • Yes • No
- Depression • Yes • No
- Nervousness • Yes • No

**EYES:**
- Wear glasses/contacts • Yes • No
- Blurred vision • Yes • No
- Cataracts • Yes • No
- Last eye exam: _____

**NOSE/EARS:**
- Allergies • Yes • No
- Sinus Trouble • Yes • No
- Hearing Loss • Yes • No
- Ringing • Yes • No

**MOUTH:**
- Dentures • Yes • No
- Hoarseness • Yes • No
- Gums • Yes • No
- Last Dental Exam: _____

**NECK:**
- Goiter/Thyroid • Yes • No
- Swollen Glands • Yes • No

**EXTREMITIES:**
- Joint pain/Swelling • Yes • No
- Gout • Yes • No
- Numbness/Tingling • Yes • No
- Varicose Veins • Yes • No
- Phlebitis • Yes • No
- Back Trouble • Yes • No

**LUNGS:**
- Persistent Cough • Yes • No
- Cough up Blood • Yes • No
- Emphysema/Bronchitis • Yes • No
- Pneumonia • Yes • No
- Last Chest X-Ray: _____

**BREASTS:**
- Nipple Discharge • Yes • No
- Do Breast Self-Exam • Yes • No
- Last Mammogram: _____

**HEART;**
- Chest Pain • Yes • No
- Shortness of Breath • Yes • No
- Heart Murmur • Yes • No
- Sleep on more than 1 pillow • Yes • No
- Palpitations • Yes • No
- Swelling of Ankles • Yes • No
- Last EKG: _____

**GASTROINTESTINAL:**
- Trouble swallowing • Yes • No
- Heartburn/Ulcer • Yes • No
- Vomiting • Yes • No
- Diarrhea • Yes • No
- Constipation • Yes • No
- Bloody/black stools • Yes • No
- Hemorrhoids • Yes • No
- Hepatitis • Yes • No

**URINARY:**
- Frequent Urination • Yes • No
- Trouble Starting • Yes • No
- Urinate During Night • Yes • No
- Leakage of Urine • Yes • No
- Blood In Urine • Yes • No
- Kidney Stones • Yes • No
- Infections • Yes • No

**GENERAL:**
- Blood Transfusion • Yes • No
- Rheumatic Fever • Yes • No
- Usual Weight: _____

**SEXUAL:**
- Problems with Sex • Yes • No
- Multiple Partners • Yes • No
- History of VD • Yes • No

*(Gonorrhea, Herpes, Syphilis, Warts, HIV)*

**WOMEN:**
- Painful Periods • Yes • No
- Irregular Periods • Yes • No
- On Birth Control Pills • Yes • No
- Form of Birth Control Used: _____
- Age Started Periods: _____
- Number of Pregnancies: _____
- Number of Children: _____
- Number of Miscarriages: _____
- Date of Last PAP Smear: _____
- Date Last Period Began: _____