GENERAL HEALTH QUESTIONNAIRE

FORT WAYNE Allergy & Asthma CONSULTANTS, INC

Patient Name: _____ Patient DOB: _____

Have you ever had any medical conditions?

Thyroid Disorder	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Type of Cancer: _____		
Heart Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
GERD (Acid Reflux)	☐ Yes	☐ No

Other **MAJOR** medical conditions:

_____

_____

_____

_____

List any major surgeries:

_____

_____

_____

_____

List all current medications:

_____

_____

_____

_____

_____

_____

_____

_____

Have you used tobacco regularly?

☐ Yes ☐ No

If yes, list below:

Age Started: _____

Duration (in years): _____

Average Amount/Day: _____

Do you still use? ☐ Yes ☐ No

Are there any animals in the house?

☐ Yes ☐ No

If yes, list below:

_____

_____

Are you allergic to any medications?

☐ Yes ☐ No

If yes, list below:

_____

_____

_____

_____

_____

Family history of allergies or asthma:

☐ Yes ☐ No

If yes, indicate below:

Mother:	☐ Yes	☐ No
Father:	☐ Yes	☐ No
Sibling(s):	☐ Yes	☐ No