Wellesley Family Care Associates

Health Questionnaire

Name: _____ **Date:** _____

Age: _____

Wellesley Family Care strives to offer you the best comprehensive medical care. It is important that your doctor receives important information regarding your lifestyle as it relates to your health. Please answer the following questions honestly. Feel free to discuss any questions or concerns you have with your provider in the examination room.

Please indicate whether any of your immediate family members suffer from any of the following:

Diabetes I or II	**YES**	**NO**	Thyroid Problems	**YES**	**NO**
Elevated cholesterol	**YES**	**NO**	High blood pressure	**YES**	**NO**
Clotting/Bleeding disorder	**YES**	**NO**	Seizure Disorder	**YES**	**NO**
Depression	**YES**	**NO**	Bipolar Disorder	**YES**	**NO**
Schizophrenia	**YES**	**NO**	Substance abuse	**YES**	**NO**
Kidney failure	**YES**	**NO**	Skin Disorders	**YES**	**NO**
Cancer	**YES**	**NO**	Infectious diseases	**YES**	**NO**
Allergies	**YES**	**NO**	Asthma	**YES**	**NO**
Eye Disorders	**YES**	**NO**	Ulcerative colitis/Crohns Disease	**YES**	**NO**

Is there anyone in your family who sustained a heart attack or stroke at an early age (<60)	**YES**	**NO**
Do you have any colon, breast, or ovarian cancer in your immediate family?	**YES**	**NO**

Family History: please list current age, health status, and chronic medical conditions of each biological family member:

Mother:

Father:

Siblings:

Children:

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Do you currently have significant problems with the following:

Fatigue	**YES**	**NO**	Chest pains	**YES**	**NO**
Weight loss/gain	**YES**	**NO**	Shortness of breath	**YES**	**NO**
Falls	**YES**	**NO**	Palpitations	**YES**	**NO**
Hearing	**YES**	**NO**	Exercise intolerance	**YES**	**NO**
Vision	**YES**	**NO**	Fainting	**YES**	**NO**
Swallowing	**YES**	**NO**	Cough	**YES**	**NO**
Nasal/sinus congestion	**YES**	**NO**	Wheezing	**YES**	**NO**
Appetite Loss	**YES**	**NO**	Sexual dysfunction	**YES**	**NO**
Heartburn	**YES**	**NO**	Urination difficulty	**YES**	**NO**
Abdominal pain	**YES**	**NO**	Night-time urination	**YES**	**NO**
Joint pains/swelling	**YES**	**NO**	Involuntary loss of urine	**YES**	**NO**
Prolonged morning stiffness	**YES**	**NO**	Loss of usual interests	**YES**	**NO**
Headaches	**YES**	**NO**	Excessive sadness	**YES**	**NO**
Sleep disturbance	**YES**	**NO**	Anger/irritability	**YES**	**NO**
Excessive anxiety	**YES**	**NO**			

Are you happy with your current weight? **YES or NO**
Do you have any dietary restrictions? **YES or NO**
Are you interested in meeting with a nutritionist? **YES or NO**

Do you drink alcohol? **YES or NO**
If yes, how many drinks per week, on average? _____
Have you ever needed to cut down on your drinking? **YES or NO**
Have you ever felt guilty about your drinking? **YES or NO**
Have you ever felt annoyed when people criticized your drinking? **YES or NO**

Do you smoke cigarettes currently? **YES or NO**
If you are a past smoker, when did you quit? _____
If you smoke currently, how many packs per day? _____
Are you interested in quitting? **YES or NO**

Do you use sunscreen daily? **YES or NO**
Do you use seatbelts regularly? **YES or NO**
Do you send text messages or emails while you are driving? **YES or NO**
Do you wear a bicycle helmet? **YES or NO**
Do you exercise? **YES or NO**
What type? How often?

Do you feel safe at home? **YES or NO**
Do you have smoke and carbon monoxide detectors in your home? **YES or NO**