

**DAVID WILKINSON, M.D., P.C.**  
**Neuromuscular Neurology : EMG Testing**

**HEALTH QUESTIONNAIRE**

The following information will help your physician in reviewing your personal health, family history and your current health habits. This will be kept in strict confidence and made part of the medical record. Please give it to your physician at the time of your appointment. Thank you for your consideration.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Social History**

Place of Birth \_\_\_\_\_ Education (Highest Level) \_\_\_\_\_

Occupation \_\_\_\_\_ How Long \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Widowed \_\_\_\_\_ Married \_\_\_\_\_ Unmarried/Partner \_\_\_\_\_

Previous Marriage(s) \_\_\_\_\_ How Long \_\_\_\_\_

Briefly list current symptoms/complains \_\_\_\_\_

**PERSONAL HISTORY**

Check any of the illnesses/medical conditions you have had:

Asthma       Heart Attack/Angina       Depression       Irritable Bowel       Kidney Disease

Chronic Bronchitis       High Blood Pressure       Epilepsy       Rectal Bleeding       Thyroid

Disease

Emphysema       High Cholesterol       Headaches/Migraines       Stomach Ulcers       Cancer

Hay Fever       Rheumatic Fever       Colon Polyps       Arthritis

type \_\_\_\_\_  Pneumonia       Stroke       Hemorrhoids       Diabetes       Atrial

Fibrillation       Tuberculosis       Anxiety       Hiatal Hernia       Other \_\_\_\_\_

**LIST OF ALL SURGERIES/OPERATIONS/HOSPITALIZATIONS**

Type \_\_\_\_\_ Year \_\_\_\_\_ Hospital/City, State \_\_\_\_\_

**FOR WOMEN ONLY:**

Number of Pregnancies \_\_\_\_\_ Number of Living Children \_\_\_\_\_

Number of Miscarriages \_\_\_\_\_ Number of Therapeutic abortions \_\_\_\_\_

Number of Cesarean Births \_\_\_\_\_ Date of Last Period \_\_\_\_\_

Date of Last PAP Smear \_\_\_\_\_ Date of Last Mammogram \_\_\_\_\_

**MEDICATIONS:** List your current prescriptions and over the counter medications.

Medication \_\_\_\_\_ Dose \_\_\_\_\_ How Often \_\_\_\_\_ Reason \_\_\_\_\_

**ALLERGIES** If so, please describe the reaction such as rash or fever.

**IMMUNIZATION HISTORY:** list date of last immunization. Influenza Vaccine (flu shot) \_\_\_\_\_

Diphtheria/Tetanus \_\_\_\_\_ Pneumovax (pneumonia) \_\_\_\_\_

Other \_\_\_\_\_

**HABITS** (Y = Yes, N = No)

Cigarette Smoking? Y or N # packs per day? \_\_\_\_\_ Number of years? \_\_\_\_\_

Smokeless Tobacco? Y or N How much/often? \_\_\_\_\_ Number of years? \_\_\_\_\_

Quit Nicotine Use? Y or N When? \_\_\_\_\_

Alcohol Use? Y or N How much/often? \_\_\_\_\_ How many years? \_\_\_\_\_  
 Quit Alcohol Use? Y or N When? \_\_\_\_\_  
 Caffeine Use? Y or N Type? \_\_\_\_\_ How much/often? \_\_\_\_\_  
 Drug Use? Y or N Type? \_\_\_\_\_ How much/often? \_\_\_\_\_  
 Exercise? Y or N Type? \_\_\_\_\_ How often? \_\_\_\_\_

**REVIEW OF SYSTEMS: Please mark all that apply.**

General: \_\_\_\_\_ Fevers \_\_\_\_\_ Weakness \_\_\_\_\_ Fatigue \_\_\_\_\_ Malaise

Head, Eyes, Ears, Nose, Throat, Lymph Nodes:

\_\_\_\_\_ Headaches \_\_\_\_\_ Head trauma \_\_\_\_\_ Visual loss or change \_\_\_\_\_ Sneezing  
 \_\_\_\_\_ Double Vision \_\_\_\_\_ Deafness \_\_\_\_\_ Nose bleeds \_\_\_\_\_ Sore throat  
 \_\_\_\_\_ Hoarseness of voice \_\_\_\_\_ Neck swelling \_\_\_\_\_ Neck Stiffness \_\_\_\_\_ Glaucoma  
 \_\_\_\_\_ Tinnitus (buzzing or humming) \_\_\_\_\_ Pain and/or drainage from ears  
 \_\_\_\_\_ Photophobia (light bothers eyes) \_\_\_\_\_ Nasal and/or sinus congestion  
 \_\_\_\_\_ Swollen and/or painful lymph nodes

Respiratory System:

\_\_\_\_\_ Shortness of breath \_\_\_\_\_ Wheezing \_\_\_\_\_ Cough  
 \_\_\_\_\_ Sputum/secretion production \_\_\_\_\_ Hemoptysis (coughing up blood)

Cardiovascular System:

\_\_\_\_\_ Chest pain, discomfort, heaviness, tightness \_\_\_\_\_ Palpitations  
 \_\_\_\_\_ Shortness of breath with exertion \_\_\_\_\_ Orthopnea (sleeping on two or more pillows)  
 \_\_\_\_\_ PND (waking up short of breath) \_\_\_\_\_ Leg swelling

Gastrointestinal System:

\_\_\_\_\_ Anorexia (poor appetite) \_\_\_\_\_ Weight loss or gain \_\_\_\_\_ Jaundice \_\_\_\_\_ Abdominal pain  
 \_\_\_\_\_ Nausea and/or vomiting \_\_\_\_\_ Hematochezia (red blood in bowel movements)  
 \_\_\_\_\_ Constipation or diarrhea \_\_\_\_\_ Melena (black bowel movements) \_\_\_\_\_ Dysphagia (difficulty swallowing)

Genitourinary System:

\_\_\_\_\_ Hematuria \_\_\_\_\_ Polyuria (urination of large volumes of urine)  
 \_\_\_\_\_ Oliguria (infrequent urination) \_\_\_\_\_ Nocturia (urination at night) \_\_\_\_\_ Pyuria (cloudy urine)  
 \_\_\_\_\_ Incontinence \_\_\_\_\_ Frequency (frequent urination) \_\_\_\_\_ Urgency (sensation to urinate)  
 \_\_\_\_\_ Heavy menstrual flow

Nervous System:

\_\_\_\_\_ Weakness/paralysis one side of body \_\_\_\_\_ Pain and/or parathesias (tingling or numbness)  
 \_\_\_\_\_ Urinary and/or fecal incontinence (wet or soil underwear)  
 \_\_\_\_\_ Memory loss, sleep disturbance, mood disorders (anxiety, depression)

Musculoskeletal System:

\_\_\_\_\_ Joint Pain \_\_\_\_\_ Muscle aches and pains \_\_\_\_\_ Back pain

Dermatological System:

\_\_\_\_\_ Rash \_\_\_\_\_ Pigmentation (Chg in color) \_\_\_\_\_ Pruritus (itching) \_\_\_\_\_ Bleeding or  
 bruising

\_\_\_\_\_ Mole Changes \_\_\_\_\_ Breast Pain

\_\_\_\_\_ Breast lumps \_\_\_\_\_ Changes in nipples  
**Present health or cause of death**

**FAMILY HISTORY**

Father living Y or N Age \_\_\_\_\_  
 Mother living Y or N Age \_\_\_\_\_  
 How many brothers living? \_\_\_\_\_  
 How many brothers deceased? \_\_\_\_\_  
 How many sisters living? \_\_\_\_\_  
 How many sisters deceased? \_\_\_\_\_  
 How many children living? \_\_\_\_\_  
 How many children deceased? \_\_\_\_\_

Present Health \_\_\_\_\_  
 Cause of Death \_\_\_\_\_  
 Present Health \_\_\_\_\_  
 Cause of Death \_\_\_\_\_  
 Present Health \_\_\_\_\_  
 Cause of Death \_\_\_\_\_

**DO YOU KNOW ANY BLOOD RELATIVES WHO HAVE OR HAD THE FOLLOWING?** Please circle and give relationship.

Asthma \_\_\_\_\_ Migraines \_\_\_\_\_ Arthritis \_\_\_\_\_ Tuberculosis \_\_\_\_\_

Depression \_\_\_\_\_

Diabetes \_\_\_\_\_ Heart Attack/Angina \_\_\_\_\_ Suicide Attempt \_\_\_\_\_ Thyroid Disease \_\_\_\_\_

High Blood Press \_\_\_\_\_ Colon Polyps \_\_\_\_\_ Cancer (type) \_\_\_\_\_ High Cholesterol \_\_\_\_\_

Colitis \_\_\_\_\_ Anesthesia Reaction \_\_\_\_\_ Stroke \_\_\_\_\_ Ulcers \_\_\_\_\_

Bleeding Problems \_\_\_\_\_ Epilepsy \_\_\_\_\_ Other \_\_\_\_\_

Patient Signature \_\_\_\_\_ Physician Signature \_\_\_\_\_