Grossman Wellness Center
2801 Youngfield St. #117
Golden, CO 80401

Terry Grossman M.D.
Bethany Wallace, D.O.

Health Questionnaire

Note: Please read carefully and fill out as completely as possible. The information provided by this questionnaire will become part of your records at our clinic. Please do not fill in the areas marked "Clinic use only."

Name: _____

Date of Birth: _____ Gender: M F

Job Title and Description_____

What main results are you looking to achieve here?_____

_____

What would you describe as your "Chief Complaint?"_____

_____

Please describe in your own words a summary of your present medical problem. Please include results of testing and evaluations done by other practitioners. (If possible, please bring any copies of lab results, other studies, and hospitalization summaries, with you.)

_____

_____

_____

_____

_____

_____

_____

List any other significant health problems you currently have which were not mentioned before:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Date of last complete physical exam_____ Date of last blood work_____

Date of last EKG_____ Did you bring copies with you?_____

Please list all current prescription medications you take (include quantity and dosage):

_____

_____

_____

To what drugs are you allergic?_____

Please describe any significant injuries in your life_____

_____

_____

Women: How many pregnancies have you had? (G)_____

How many deliveries? (P)_____Miscarriages/Abortions_____

Please list all hospitalizations (do not include emergency room visits)

REASON FOR ADMISSION	DATE	NAME OF HOSPITAL

Please describe your current diet: _____

_____

_____

If you know your blood type, please write it here _____

How much has your weight changed in the past 6 months? Gained_____or lost_____pounds

Please describe your current pattern of exercise, including type, duration and times per week

_____

_____

_____

Please list below all the vitamins and supplements you take regularly:

NAME	STRENGTH	QUANTITY

Allergies to foods_____

Allergies to animals, chemicals or other airborne substances_____

_____

Do you now or have you ever smoked or used tobacco?_____ Details:_____

_____

Alcohol?_____ Amount per week_____

Coffee_____cups per day Sodas_____per day diet or regular_____

Do you take any over the counter medications? (Aspirin, antacids, ect.)_____

_____

_____

Review of systems:

Do you currently have or have You had any problems with?	Please describe:	Clinic use only
Head,eyes,ears,nose,throat		
Heart/cardiovascular system		
Lungs		
Diabetes or hypoglycemia		
Lymph system		
Musculoskeletal system		
Digestive problems		
Neurological probs/headache		
Urinary tract problems		
Sleep problems		

Psychological problems		
Sexual problems		
Skin Problems		
Neck or back problems		
Other:		

Family History:

Has anyone in your family suffered the same problem as your "chief complaint?"

Relative	Alive? Yes or no	Age now or Age at death	Health history or cause Of death
Mother			
Father			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			

Children			
Other			

Please list any other special items you might wish to discuss with us:

_____

_____

_____

Please sign and date below:

_____ _____