EASA: General Health Questionnaire

Date_____ ID#_____Name_____
DOB_____ Age_____ ❒ Male ❒ Female ❒ Other
Allergies: _____ Medication _____Food _____Environmental
Please list:_____
_____
Primary Care Provider_____ PCP's Phone #_____
Clinic _____ City_____

Ht. _____ Wt. _____ Waist_____ b/p _____ P _____

Do you smoke cigarettes?_____ If yes, amount?____day/week At what age did you begin smoking?_____
Are you currently exposed to second hand smoke?_____ Would you like to quit smoking?_____

Do you drink alcohol?_____ If yes, amount? _____daily, weekly, or monthly? At what age did you begin drinking?_____ Have you ever experienced a blackout?_____

Do you take street drugs?_____ If yes, what is your drug of choice?_____
Which drug do you take most often?_____ Amount?_____ Frequency?_____
What route(s) do you use? (i.e. smoking, snorting, injecting, etc…)_____
At what age did you begin using? _____ Have you ever sought and/or received treatment ?_____
If so, where?_____ Was it effective?_____

Do you gamble?_____ If yes, what is your favorite game?_____
Has anyone ever told you this is a problem for you?_____ Have you ever sought and/or received treatment?_____ If so, where?_____

Please check all that apply:	Self		Self	Family	Relationship
Frequent headaches	❒	Cardiovascular disease	❒	❒	_____
Dizziness or fainting	❒	Kidney disease	❒	❒	_____
Nausea and/or vomiting	❒	Liver disease	❒	❒	_____
Diarrhea or constipation	❒	Diabetes Mellitus	❒	❒	_____
Frequent voiding	❒	Thyroid dysfunction	❒	❒	_____
Frequent thirst	❒	Other_____	❒	❒	_____

Which meals do you regularly eat during the day? _____ breakfast _____ lunch _____ dinner
With whom do you eat your meals?_____
Throughout the day, how often do you snack?_____ Are there certain times during the day when you are more apt to snack than others?_____ When?_____
What type of foods do you snack on?_____

What type of beverages do you drink?_____
How much of each type do you drink on an average day?_____
_____
Do you drink water on a regular basis?_____ If so, how much every day?_____

How do you sleep during the night?_____ Do you have trouble falling asleep?_____
Staying asleep? _____ Waking too early?_____ On average, approximately how many hours do you sleep each night?_____ Do you remember your dreams?_____

Do you take walks?_____ Ride a bicycle?_____ Jog?_____ Swim?_____ Run up & down stairs throughout the day?_____ Do you have a regular exercise routine?_____
If so, what is it?_____
Are you currently taking any medications, vitamins, or supplements? If so, please list_____
_____

Are you sexually active?_____ How many partners have you had in the past year? _____
What form, if any, of protection do you use?_____
Have you ever been treated for a STI?_____If female, do you believe you are currently pregnant?_____
If so, how far into your pregnancy are you?_____

Would you like a copy of this form for your personal records?_____

For office use only:_____