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<b>HEALTH QUESTIONNAIRE</b>				
REASON FOR VISIT				
FAMILY HISTORY		IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING – PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE		
1. Epilepsy	6. Thyroid	11. Osteoporosis	16. High cholesterol	
2. Migraine	7. Hay fever	12. Arthritis	17. Alcoholism	
3. Mental illness	8. Asthma	13. Heart disease	18. Hepatitis	
4. Glaucoma	9. Anemia	14. Stoke	19. Cancer	
5. Diabetes	10. Bleeds easily	15. High blood pressure	20. Others please specify:	
HOSPITAL ADMISSIONS  not including pregnancies	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION
LIST ALL MEDICATIONS YOU ARE NOW TAKING - INCLUDING THOSE YOU BUY WITHOUT PRESCRIPTION		ALLERGIES	VACCINE	YEAR OF LAST TEST/EXAM YEAR OF LAST
			Tetanus/Td _____	Colonoscopy _____
		SUPPLEMENTS	Influenza _____	Rectal Exam _____
			Pneumonia _____	Mammogram _____
			Hepatitis _____	TB Test _____
MEDICAL HISTORY		MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES		
<input type="checkbox"/> Heart murmur <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Irregular pulse <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of breath <input type="checkbox"/> On exertion <input type="checkbox"/> Lying flat <input type="checkbox"/> Leg pain: when walking <input type="checkbox"/> Mental illness <input type="checkbox"/> German measles <input type="checkbox"/> Loss of appetite: recent <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Heart burn <input type="checkbox"/> Peptic Ulcer <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Jaundice/hepatitis <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Decreased energy <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Chicken pox <input type="checkbox"/> Polio	<input type="checkbox"/> Ringing in ear <input type="checkbox"/> Ear infections – frequent <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Fainting spells <input type="checkbox"/> Nose bleeds - recurrent <input type="checkbox"/> Failing vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Double or blurred vision <input type="checkbox"/> Sinus trouble <input type="checkbox"/> Sore throats – frequent <input type="checkbox"/> Hoarseness – prolonged <input type="checkbox"/> Hay fever / Allergies <input type="checkbox"/> Pneumonia / Pleurisy <input type="checkbox"/> Bronchitis / Chronic cough <input type="checkbox"/> Asthma / Wheezing <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Hernia <input type="checkbox"/> Crohn's / Colitis <input type="checkbox"/> Inflamm. Bowel Syndrome <input type="checkbox"/> Bloody or tarry stools <input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Urination: Incontinence <input type="checkbox"/> Urination: Blood <input type="checkbox"/> Kidney stones <input type="checkbox"/> Tremor/ Hands shaking <input type="checkbox"/> Headaches <input type="checkbox"/> Numbness <input type="checkbox"/> Arthritis / Rheumatism <input type="checkbox"/> Bone fracture/ joint injury <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Back Pain <input type="checkbox"/> Foot pain <input type="checkbox"/> Gout <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Depression <input type="checkbox"/> Nervousness <input type="checkbox"/> Memory loss <input type="checkbox"/> Appetite <input type="checkbox"/> Bruise easily <input type="checkbox"/> Anemia <input type="checkbox"/> Weight Loss/ gain <input type="checkbox"/> Height loss <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Cancer <input type="checkbox"/> Easily fatigued <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Mumps	<input type="checkbox"/> Measles <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes <input type="checkbox"/> STD <input type="checkbox"/> AIDS/ HIV <input type="checkbox"/> Sexual problems <input type="checkbox"/> Sleep problem How long _____ How frequent _____ <input type="checkbox"/> Alcohol _____ oz/week <input type="checkbox"/> Coffee/Tea _____ cup/day <input type="checkbox"/> Smoking _____ cig/day _____ #yrs Year quit _____ Hair Loss: <input type="checkbox"/> Progressive <input type="checkbox"/> Recent <b>MALES -</b> <input type="checkbox"/> Prostate Problems <b>FEMALES</b> <input type="checkbox"/> B.C.pill name _____ <input type="checkbox"/> Flushing menopause	
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