## EASA: General Health Questionnaire

<table>
<thead>
<tr>
<th>Date</th>
<th>ID#</th>
<th>Name</th>
<th>DOB</th>
<th>Age</th>
<th>Gender</th>
<th>Allergies:</th>
<th>Medication</th>
<th>Food</th>
<th>Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please list:**

<table>
<thead>
<tr>
<th>Primary Care Provider</th>
<th>PCP’s Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ht.</th>
<th>Wt.</th>
<th>Waist</th>
<th>b/p</th>
<th>P</th>
</tr>
</thead>
</table>

- 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:**

<table>
<thead>
<tr>
<th>Self</th>
<th>Family</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Frequent headaches [ ]
  - Cardiovascular disease [ ]
  - Thyroid dysfunction [ ]
  - Other [ ]

- Dizziness or fainting [ ]
  - Kidney disease [ ]
  - Diabetes Mellitus [ ]

- Nausea and/or vomiting [ ]
  - Liver disease [ ]

- Diarrhea or constipation [ ]
  - Frequent voiding [ ]

- Frequent thirst [ ]

**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:______________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________