KHIN KHIN OO, M.D., INC.
HEALTH ASSESSMENT QUESTIONNAIRE

Name _____

Date _____ Date of Birth _____

Past Medical Problems (Operations, Illness, Injury)			**Present or Recurrent Medical Problems**	
Year	**Problem**	**Hospital**	**Date of Onset**	**Problem**

Medications (Please include doses and frequencies)

1		**6**	
2		**7**	
3		**8**	
4		**9**	
5		**10**	

Allergies to Medications (Please include reaction; rash, vomiting, etc.)

1		**5**	
2		**6**	
3		**7**	
4		**8**	

Family History

Relationship	Age if Living	Age at Death	State of Health or Cause of Death
Father			
Mother			
Siblings			
Children			

Illness	Family Member with Illness	Age at Onset
Breast Cancer		
Colon Cancer		
Prostate Cancer		
High Blood Pressure		
Heart Disease		
Diabetes		

Health Habits

Habits	Yes	No	How Much and What Kind?
Tobacco	○	○	
Alcohol	○	○	
Caffeine	○	○	
Drugs	○	○	
Exercise	○	○	

Health Screening

Test	Done		Last Date	Any Abnormalities?
	Yes	No		
Mammogram	○	○		
Colonoscopy	○	○		
Cholesterol	○	○		
Pap Smear	○	○		
Eye Exam	○	○		
Prostate Physical Exam	○	○		
Bone Density Test	○	○		

Immunization History

Immunization	Last Given Date
Flu Shot	
Pneumonia Shot	
Shingles Shot	
Whooping Cough & Tetanus Shot	
Tetanus Shot	
HPV Shot	
Other	