

**HOWARD HOLTZ, M.D.  
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SUITE 205  
WEST ORANGE, NJ 07052**

**HEALTH QUESTIONNAIRE**

1. **Name:** \_\_\_\_\_  
**(First) (Last) (M.I.)**

2. **Sex:** \_\_\_\_\_ **Female** \_\_\_\_\_ **Male**

3. **Date of Birth:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

4. **Marital Status** \_\_\_\_\_ **How long?** \_\_\_\_\_

5. **Name of closest relative, significant other, or friend:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Tel. # (Home)** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

6. **Who filled out this form:** \_\_\_\_\_

**Relationship, if other than patient:** \_\_\_\_\_

7. **Who has been your previous family (primary) doctor?**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Telephone No.** \_\_\_\_\_

8. With whom do you live? \_\_\_\_\_

9. Which of the following best describes your residence: (check one)

1. \_\_\_\_\_ own house or condo
2. \_\_\_\_\_ rent house, condo, apartment or room(s)
3. \_\_\_\_\_ live with other in their home, condo, apartment
4. \_\_\_\_\_ board and care/residential care facility
5. \_\_\_\_\_ other, specify \_\_\_\_\_

10. Does someone prepare your meals for you? Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered yes, who prepares your meals? \_\_\_\_\_

11. Are you currently (check all that apply)

1. \_\_\_\_\_ retired/semi-retired
2. \_\_\_\_\_ working full time
3. \_\_\_\_\_ working part time
4. \_\_\_\_\_ looking for work

12. What has been your principal occupation? \_\_\_\_\_

13. How much school did you complete? \_\_\_\_\_

14. Do you have a Medical Durable Power of Attorney? (Someone to make medical decisions for you if you are not able.)

Yes \_\_\_\_\_ No \_\_\_\_\_

15. Do you have a Living Will (Advanced Directive)?

Yes \_\_\_\_\_ No \_\_\_\_\_

16. Please describe any military service:

\_\_\_\_\_

**17. How important is religion or spirituality in your life?**

\_\_\_\_\_

**18. Do you employ someone to provide care for you or help you in your home? Yes \_\_\_\_\_ No \_\_\_\_\_**

**Name** \_\_\_\_\_

**19. Do you provide care for a family member? Yes \_\_\_\_\_ No \_\_\_\_\_**

**If yes, which family member?** \_\_\_\_\_

**How old is this family member?** \_\_\_\_\_

**20. If you answered yes to providing care for a family member, check all that apply to your situation.**

- 1. \_\_\_\_\_ **live with family member**
- 2. \_\_\_\_\_ **totally responsible for the care of this person**
- 3. \_\_\_\_\_ **need assistance to find resources to help with care of this family member.**
- 4. \_\_\_\_\_ **Need assistance to obtain time away from caring for this family member.**

**21. We want to know if you need help with any of the following, and who helps you. Check and fill in for each task.**

<b>TASK</b>	<b>DON'T NEED HELP</b>	<b>NEED HELP</b>	<b>IF YOU NEED HELP WHO HELPS?</b>
<b>Feeding yourself</b>	_____	_____	_____
<b>Getting from bed to chair</b>	_____	_____	_____
<b>Getting to the toilet</b>	_____	_____	_____

<b><u>TASK</u></b>	<b><u>DON'T NEED HELP</u></b>	<b><u>NEED HELP</u></b>	<b><u>IF YOU NEED HELP WHO HELPS?</u></b>
<b>Getting dressed</b>	_____	_____	_____
<b>Bathing</b>	_____	_____	_____
<b>Using telephone</b>	_____	_____	_____
<b>Taking medications</b>	_____	_____	_____
<b>Preparing Meals</b>	_____	_____	_____
<b>Managing money/ financial affairs/ checkbook</b>	_____	_____	_____
<b>Doing laundry</b>	_____	_____	_____
<b>Doing housework</b>	_____	_____	_____
<b>Shopping for food</b>	_____	_____	_____
<b>Driving</b>	_____	_____	_____
<b>Doing handyman work</b>	_____	_____	_____
<b>Climbing a flight of stairs</b>	_____	_____	_____
<b>Getting to places beyond walking distance</b>	_____	_____	_____

**22. Which medical conditions do you have now, or have you had in the past? (check all that apply)**

**EYE AND EAR PROBLEMS**

- a.  cataracts
- b.  glaucoma
- c.  macular degeneration  
of the eye
- d.  hearing loss/  
hearing aid
- e.  wear glasses or  
contact lenses
- f.  other, specify:

**HEART PROBLEMS**

- a.  angina
- b.  heart attack  
year \_\_\_\_\_
- c.  heart failure
- d.  irregular or rapid  
heartbeat
- e.  passing out,  
fainting
- f.  other, specify:

**LUNG PROBLEMS**

- a.  asthma
- b.  bronchitis
- c.  lung cancer
- d.  emphysema
- e.  other, specify

**BONE AND JOINT PROBLEMS**

- a.  arthritis
- b.  osteoporosis
- c.  fractured hip,  
wrist or spine  
(circle which one)
- d.  gout
- e.  falls
- f.  other, specify:

**GLAND PROBLEMS**

- a.  diabetes
- b.  thyroid overactive (high)
- c.  thyroid underactive (low)
- d.  other, specify \_\_\_\_\_  
\_\_\_\_\_

**KIDNEY AND URINARY  
PROBLEMS**

- a.  kidney disease
- b.  prostate disease
- c.  frequent bladder  
or kidney infection
- d.  blood in urine
- e.  other \_\_\_\_\_

**GASTROINTESTINAL  
PROBLEMS**

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- a. \_\_\_\_\_ ulcers
- b. \_\_\_\_\_ heartburn/hiatal  
hernia
- c. \_\_\_\_\_ diverticulosis
- d. \_\_\_\_\_ liver disease/  
cirrhosis
- e. \_\_\_\_\_ hepatitis
- f. \_\_\_\_\_ polyps
- g. \_\_\_\_\_ gallbladder disease
- h. \_\_\_\_\_ other, specify:

**NERVOUS SYSTEM  
PROBLEMS**

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- a. \_\_\_\_\_ stroke
- b. \_\_\_\_\_ memory problems
- c. \_\_\_\_\_ Parkinson's  
disease
- d. \_\_\_\_\_ epilepsy/seizures
- e. \_\_\_\_\_ other, specify:

**OTHER HEALTH PROBLEMS**

- a. \_\_\_\_\_ anemia
- b. \_\_\_\_\_ hernia
- c. \_\_\_\_\_ thrombosis  
(blood clots)
- d. \_\_\_\_\_ cancer, specify:
- e. \_\_\_\_\_ depression
- f. \_\_\_\_\_ sexual function problem
- g. \_\_\_\_\_ skin disease
- h. \_\_\_\_\_ Other, specify:

**23. Do you ever drink alcohol, including beer and/or wine? (check one)**

- a. \_\_\_\_\_ daily
- b. \_\_\_\_\_ greater than 3 times a week
- c. \_\_\_\_\_ 1-3 times a week
- d. \_\_\_\_\_ Less than 1 time a week
- e. \_\_\_\_\_ Never

**24. During the last month, what is the greatest number of alcoholic drinks you have consumed in one day? \_\_\_\_\_**

**25. Have you ever smoked cigarettes?**

1. \_\_\_\_\_ **No**
2. \_\_\_\_\_ **Yes – If yes, are you now smoking?**
  - a) \_\_\_\_\_ **No. If no,**
    - 1) **How many years ago did you quit?** \_\_\_\_\_
    - 2) **For how many years did you smoke?** \_\_\_\_\_
    - 3) **How much did you smoke:**  
\_\_\_\_\_ **packs of cigarettes a day or**  
\_\_\_\_\_ **cigarettes a day**
  - b) \_\_\_\_\_ **Yes, if yes,**
    - 1) **How many years have you smoked?**
    - 2) **How much do you smoke?**  
\_\_\_\_\_ **packs of cigarettes a day or**  
\_\_\_\_\_ **cigarettes a day**

**26. Have you ever smoked a pipe, cigar or chewed tobacco?**

1. \_\_\_\_\_ **No**
2. \_\_\_\_\_ **Yes – If yes, are you still smoking or chewing?**

**27. Have any members of your family had any of the following conditions?**

- 1) \_\_\_\_\_ **Dementia, senility or Alzheimer's disease**
- 2) \_\_\_\_\_ **Cancer: of what?** \_\_\_\_\_
- 3) \_\_\_\_\_ **Heart Disease, heart attack**
- 4) \_\_\_\_\_ **Stroke**
- 5) \_\_\_\_\_ **Diabetes**
- 6) \_\_\_\_\_ **Depression**
- 7) \_\_\_\_\_ **Hypertension**
- 8) \_\_\_\_\_ **Osteoporosis**
- 9) \_\_\_\_\_ **Other, specify** \_\_\_\_\_

**28. Do you always wear a seatbelt when you ride in the car?**

- 1) \_\_\_\_\_ **No**
- 2) \_\_\_\_\_ **Yes**

**CURRENT SYMPTOMS OR PROBLEMS**

**29. To be certain that we've covered everything: during the last three months, have you had any of the following symptoms or problems? (Check all that apply)**

**EYE OR EAR PROBLEMS**

- a) \_\_\_\_\_ **problems seeing**
- b) \_\_\_\_\_ **other eye problems**
- c) \_\_\_\_\_ **hearing difficulty**
- d) \_\_\_\_\_ **ear trouble**

**HEART PROBLEMS**

- a) \_\_\_\_\_ **chest pain or tightness**
- b) \_\_\_\_\_ **rapid or irregular heart beats**

**LUNG PROBLEMS**

- a) \_\_\_\_\_ **persistent cough**
- b) \_\_\_\_\_ **difficulty breathing or shortness of breath**

**BRAIN OR NERVOUS SYSTEM PROBLEMS**

- a) \_\_\_\_\_ **frequent headaches**
- b) \_\_\_\_\_ **frequent dizzy spells**
- c) \_\_\_\_\_ **passing out or fainting**
- d) \_\_\_\_\_ **paralysis, leg or arm weakness**
- e) \_\_\_\_\_ **numbness or loss of feeling anywhere**
- f) \_\_\_\_\_ **serious problem with memory or difficulty thinking**
- g) \_\_\_\_\_ **tremor or shaking**

**WOMEN'S PROBLEMS**

- a) \_\_\_\_\_ **vaginal bleeding**
- b) \_\_\_\_\_ **vaginal discharge**
- c) \_\_\_\_\_ **breast lumps or discomfort**

**DIGESTION PROBLEMS**

- a) \_\_\_\_\_ dental problems
- b) \_\_\_\_\_ difficulty swallowing
- c) \_\_\_\_\_ frequent indigestion or stomach discomfort/pain
- d) \_\_\_\_\_ frequent nausea/vomiting
- e) \_\_\_\_\_ change in bowel habits
- f) \_\_\_\_\_ weight loss - how many pounds? \_\_\_\_\_
- g) \_\_\_\_\_ black bowel movements or bleeding from rectum
- h) \_\_\_\_\_ frequent diarrhea
- i) \_\_\_\_\_ persistent constipation

**OTHER HEALTH PROBLEMS**

- a) \_\_\_\_\_ difficulty with sleeping
- b) \_\_\_\_\_ falling, stumbling or balance problems
- c) \_\_\_\_\_ swelling feet or ankles
- d) \_\_\_\_\_ fever or sweats
- e) \_\_\_\_\_ other: \_\_\_\_\_

**KIDNEY AND URINARY TRACT PROBLEMS**

- a) \_\_\_\_\_ urination at night
- b) \_\_\_\_\_ frequent urination
- c) \_\_\_\_\_ difficulty starting or stopping urination

**BONE AND JOINT PROBLEMS**

- a) \_\_\_\_\_ leg pain on walking
- b) \_\_\_\_\_ back or neck pain
- c) \_\_\_\_\_ joint pain or stiffness
- d) \_\_\_\_\_ foot problems
- e) \_\_\_\_\_ leg pain in bed

**30. In past 12 months, have you ever lost your urine or gotten wet?**

- 1) \_\_\_\_\_ No
- 2) \_\_\_\_\_ Yes. If yes, have you lost your urine on at least six separate days? \_\_\_\_\_ No \_\_\_\_\_ Yes

**31. Have you ever had an examination of your bowel with a scope (colonoscopy)?**

- 1) \_\_\_\_\_ No
- 2) \_\_\_\_\_ Yes. If yes, when did you have your most recent examination? Year \_\_\_\_\_

**32. In the past 12 months, have you had a test for blood in your stool?**

1) \_\_\_\_\_ **No**                      2) \_\_\_\_\_ **Yes**

**33. Have you had your flu shot this season (September-February)?**

1) \_\_\_\_\_ **No**                      2) \_\_\_\_\_ **Yes**

**34. Have you ever had the Pneumovax vaccine (shot to prevent Pneumonia)?**

1) \_\_\_\_\_ **No**

2) \_\_\_\_\_ **Yes** - If yes, in what year did you have your last  
Pneumovax vaccine? Year \_\_\_\_\_

**35. Have you ever had a Tetanus Shot?**

1) \_\_\_\_\_ **No**

2) \_\_\_\_\_ **Yes** - If yes, in what year did you have your last tetanus  
booster? Year \_\_\_\_\_

**36. Have you ever had a shot to prevent shingles (Zostavax)?**

1) \_\_\_\_\_ **No**

2) \_\_\_\_\_ **Yes** - If yes, in what year \_\_\_\_\_

**QUESTIONS FOR WOMEN ONLY**  
**(\* Men please skip to question 40)**

**37. Have you had a bone density test to detect osteoporosis (thinning of the bones)?**

1) \_\_\_\_\_ No                      2) \_\_\_\_\_ Yes

**38. Have you had a mammogram? (x-ray of the breasts)**

1) \_\_\_\_\_ No

2) \_\_\_\_\_ Yes – If yes, have you had a mammogram within the last 2 years?

\_\_\_\_\_ No

\_\_\_\_\_ Yes,    Month \_\_\_\_\_ Year \_\_\_\_\_

**39. Have you had a hysterectomy (surgical removal of the womb)?**

1) \_\_\_\_\_ No – If no, have you ever had a pelvic (internal) examination and a pap smear?

\_\_\_\_\_ No

\_\_\_\_\_ Yes, If yes, when was your last pap smear?

Month \_\_\_\_\_ Year \_\_\_\_\_

3) \_\_\_\_\_ Yes

**(After completing question 40, please go to question 42)**

**For Office Use**

**Clinical risk factors for O.P. fracture that are independent of BMD**

**Advancing age**

**Previous fracture**

**Glucocorticoid therapy**

**Parental history of hip fracture**

**Low body weight**

**Cigarette smoking**

**Excessive alcohol consumption**

**Rheumatoid arthritis**

## **QUESTIONS FOR MEN ONLY**

**40. Have you ever had a prostate exam (rectal exam)?**

**1) \_\_\_\_\_ No**

**2) \_\_\_\_\_ Yes, If yes, when did you have your most recent prostate exam? Year \_\_\_\_\_**

**41. Have you ever had a blood test to look for prostate cancer (PSA)?**

**1) \_\_\_\_\_ No**

**2) \_\_\_\_\_ Yes – If yes, when did you have your most recent blood test to look for prostate cancer: Year \_\_\_\_\_**



**44. List operations (surgeries) Use back of page if needed.**

<u>DATE</u>	<u>OPERATION (SURGERY)</u>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

**45. List other hospitalizations or injuries. Use back of page if needed.**

<u>DATE</u>	<u>REASON FOR HOSPITALIZATION</u>
<hr/>	<hr/>
<hr/>	<hr/>

**46. List other doctors/specialists that you see.**

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**FOR PROVIDER USE ONLY**

**Reviewed and discussed with the patient on \_\_\_\_\_**

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**Howard Holtz, M.D.**