Albert Pujols Wellness Center
for Adults with Down Syndrome
Health Questionnaire

Name: ____________________________________ Date: _______________________

Please circle appropriate responses below if you CURRENTLY are having any problems. This will be used to enhance your visit with your Physician

General/Constitutional

Headaches	Yes	No
Recent Illness	Yes	No
Hot/Cold	Yes	No
Fatigue/Decreased Energy	Yes	No
Fever	Yes	No
Night Sweats	Yes	No
Weight change	Yes	No

HEENT/Neck

Teeth/Gum issues	Yes	No
Seasonal Allergies	Yes	No
Double vision	Yes	No
Ear pain/Drainage	Yes	No
Hearing loss	Yes	No
Nose bleeds	Yes	No
Hoarseness	Yes	No
Mouth Ulcers	Yes	No
Sore throat	Yes	No
Swollen Lymph Nodes	Yes	No

Respiratory

Persistent cough	Yes	No
Shortness of breath with rest	Yes	No
Tobacco use	Yes	No
Wheezing	Yes	No

Cardiovascular

Chest pain/discomfort	Yes	No
Palpitations	Yes	No
Swelling in legs/feet/hands	Yes	No
Varicose veins	Yes	No

Gastrointestinal

Trouble Swallowing	Yes	No
Abdominal Pain	Yes	No
Appetite Change	Yes	No
Blood in Stool	Yes	No
Change in bowel habit	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Nausea	Yes	No
Vomiting	Yes	No

Genitourinary

Discharge from genitals	Yes	No
Breast pain/mass/discharge	Yes	No
Frequent urination	Yes	No
Menopausal	Yes	No
Abnormal menstrual bleeding	Yes	No
Blood in urine	Yes	No
Difficulty urinating	Yes	No
Sexual Difficulty	Yes	No

Musculoskeletal

Difficulty walking	Yes	No
Difficulty with tasks	Yes	No
Calf pain	Yes	No
Back pain	Yes	No
Joint pain	Yes	No
Joint Swelling	Yes	No

Dermatologic

Bruising	Yes	No
Skin Color/Mole changes	Yes	No
Rash	Yes	No

Neurologic

Frequent Headaches	Yes	No
Dizzy/Light Headed	Yes	No
Tingling/Numbness	Yes	No
Trouble with Balance	Yes	No

Psychiatric

Anxiety	Yes	No
Depression	Yes	No
Memory loss	Yes	No
Sleep disturbances	Yes	No
Suicidal thoughts	Yes	No

List of Medications

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________
13. ______________________________

Last colonoscopy:________

Women Only:
Last GYN visit:___________
Last Mammogram:________

Men Only:
Last PSA:_______________

Do you smoke?
Yes No

Do you see any specialists?
Please list below.
Dentist:
Dermatologist:
Primary Care Physician Name:
____

Surgeries in the past year

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

List of Immunizations in past year

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________