HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name: *Last* *First* *MI*

Today's Date: **Reason for Visit:**

Previous or referring doctor:	**Patient sex :** ☐ **M** ☐ **F**	**DOB:**

PERSONAL HEALTH HISTORY (PAST MEDICAL HISTORY)

Conditions you have had in the past (check all that apply):

□ AIDS/HIV +	□ Bulimia	□ Goiter	□ Liver Disease	□ Stroke
□ Alcoholism	□ Cancer	□ Gonorrhea	□ Migraine Headache	□ Suicide Attempt
□ Anemia	□ Cataracts	□ Gout	□ Mononucleosis	□ Thyroid Problems
□ Anorexia	□ Chem Dependancy	□ Heart Disease	□ Multiple Sclerosis	□ TB
□ Arthritis	□ Chicken Pox	□ Hepatitis	□ Pneumonia	□ Ulcers
□ Asthma	□ Diabetes	□ Hernia	□ Polio	LIST ANY OTHERS
□ Bleeding Disorders	□ Emphysema	□ Herpes	□ Prostate Problem	□
□ Breast Lump	□ Epilepsy	□ High Cholesterol	□ Rheumatic Fever	□
□ Bronchitis	□ Glaucoma	□ Kidney Disease	□ Scarlet Fever	□

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Do you know your blood type? ☐ Yes ☐ No Type:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Strength	Frequency Taken	**Drug Name**	Strength	Frequency Taken
1			9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8			16		

Allergies to medications

Drug Name	**Reaction You Had**	**Drug Name**	**Reaction You Had**
1		3	
2		4	

PATIENT NAME: **DOB:**

HEALTH HABITS AND PERSONAL SAFETY (SOCIAL HISTORY)

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise) ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)						
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)						
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)						
Diet	Are you dieting?				☐	Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐	Yes	☐ No
	# of meals you eat in an average day?						
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola			
	# of cups/cans per day?						
Alcohol	Do you drink alcohol?				☐	Yes	☐ No
	If yes, what kind?						
	How many drinks per week?						
Tobacco	Do you use tobacco?				☐	Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day			
	☐ # of years	☐ Or year quit					
Drugs	Do you currently use recreational or street drugs?				☐	Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐	Yes	☐ No
Personal Safety	Do you live alone?				☐	Yes	☐ No
	Do you have frequent falls?				☐	Yes	☐ No
	Do you have vision or hearing loss?				☐	Yes	☐ No
	Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your doctor or his staff?				☐	Yes	☐ No

FAMILY HEALTH HISTORY

Relation	AGE	AGE AT DEATH	SIGNIFICANT HEALTH PROBLEMS
Father			
Mother			
Brothers			
Sisters			

MENTAL HEALTH

Is stress a major problem for you?	☐	Yes	☐	No
Do you feel depressed?	☐	Yes	☐	No
Do you panic when stressed?	☐	Yes	☐	No
Do you have problems with eating or your appetite?	☐	Yes	☐	No
Do you cry frequently?	☐	Yes	☐	No
Have you ever seriously thought about hurting yourself?	☐	Yes	☐	No
Do you have trouble sleeping?	☐	Yes	☐	No
Have you ever been to a counselor?	☐	Yes	☐	No

SCREENINGS (please indicate most recent date)

Last Colonoscopy:	☐ Normal ☐ Abnormal	Cholesterol Screening:	☐ Normal ☐ Abnormal
Test for blood in stools:	☐ Normal ☐ Abnormal	Electrocardiogram:	☐ Normal ☐ Abnormal

PATIENT NAME: **DOB:**

Review Of Systems (check all that apply to you)

CONSTITUTIONAL
- ☐ Wt. loss or gain
- ☐ Fever
- ☐ Fatigue
- ☐ Chills

EYES
- ☐ Blurry vision
- ☐ Double vision
- ☐ Vision changes
- ☐ Cataracts
- ☐ Glaucoma

ENT/MOUTH
- ☐ Sinus problems
- ☐ Runny nose
- ☐ Tooth pain
- ☐ Hearing loss
- ☐ Ringing ears
- ☐ Gum pain
- ☐ Gum bleeding
- ☐ Swallowing difficulties
- ☐ Ear pain
- ☐ Ear discharge

ALLERGY/IMMUNO
- ☐ Rashes/hives/wealts
- ☐ Itchiness
- ☐ Allergic asthma/bronchitis

NEURO
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Headache
- ☐ Lack of coordination
- ☐ Balance problems
- ☐ Seizures
- ☐ Numbness

PSYCH
- ☐ Depression
- ☐ Mood swings
- ☐ Memory problems
- ☐ Anxiety

ENDO
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Nail changes
- ☐ Night sweats
- ☐ Hot flashes

SKIN
- ☐ Skin rashes
- ☐ Bruising
- ☐ Changes in skin lesions
- ☐ Wounds
- ☐ Ulcers

GENITOURINARY
- ☐ Burning urination
- ☐ Excessive urination
- ☐ Incontinence of urine
- ☐ Blood in urine
- ☐ Frequent bladder/kidney infections
- ☐ History of sexually transmitted disease

GASTROINTESTINAL
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Incontinence of bowels
- ☐ Blood in stools
- ☐ Bloating
- ☐ Poor appetite
- ☐ Hemorrhoids
- ☐ Nausea

HEM/LYMPH
- ☐ Bruising
- ☐ Nosebleeds
- ☐ Lack of energy

RESPIRATORY
- ☐ Frequent lung infections
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Wheezing
- ☐ Sleeping problems
- ☐ Persistent cough
- ☐ Asthma

CARDIOVASCULAR
- ☐ History of Rheumatic fever
- ☐ Palpitations
- ☐ Chest pain
- ☐ Swelling hands
- ☐ Swelling feet
- ☐ Irregular heart beat
- ☐ High or low blood pressure

MUSC/SKELETAL
- ☐ Difficulty walking
- ☐ Joint stiffness
- ☐ Muscle pains
- ☐ Back pain
- ☐ Pain during walking

WOMEN ONLY

Age at menstruation:		Date of last PAP smear:	☐ Normal ☐ Abnormal
Number of pregnancies _____ Number of live births _____		Date of or age at last menstruation:	
Last Mammogram:	☐ Normal ☐ Abnormal	Bone Density Screening:	☐ Normal ☐ Abnormal

Experienced any recent breast tenderness, lumps, or nipple discharge?	☐	Yes	☐	No
Date of last rectal exam? ☐ Normal ☐ Abnormal				

MEN ONLY

Do you usually get up to urinate during the night?	☐	Yes	☐	No
If yes, # of times _____				
Do you feel burning discharge from penis?	☐	Yes	☐	No
Has the force of your urination decreased?	☐	Yes	☐	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐	Yes	☐	No
Do you have any problems emptying your bladder completely?	☐	Yes	☐	No
Any difficulty with erection or ejaculation?	☐	Yes	☐	No
Any testicle pain or swelling?	☐	Yes	☐	No

Date of last prostate and rectal exam?	☐ Normal ☐ Abnormal
Date of last PSA test (if any):	☐ Normal ☐ Abnormal

Is there anything else you would like to discuss with the doctor?

_____

_____

I have reviewed this history with the patient for accuracy and completeness:

_____

Physician signature and date