HEALTH HISTORY QUESTIONNAIRE

Name: ______________________ Age: ________ Date: ________

Address: ____

Telephone #: ________________ Date of Birth ____________

PAST MEDICAL HISTORY

Have You: **If Yes,**

Had any serious illnesses?........... No Yes Please List: ____________
Ever been hospitalized?............... No Yes For What? ____________
Had any surgeries? .... No Yes Please List: ____________
Had any broken bones? .... No Yes Which Ones? ____________
Had any head injuries? .... No Yes When? ____________

Have you ever had:

Cancer? .... No Yes
Pneumonia?............. No Yes
Tuberculosis ?.......... No Yes
Chicken Pox? .... No Yes
Measles? .... No Yes

Mumps? .... No Yes
Heart Disease?............ No Yes
Stroke? .... No Yes
Diabetes? .... No Yes
Hepatitis? .... No Yes

High Blood Pressure? .... No Yes
High Cholesterol? .... No Yes
Blood Clots? .... No Yes
Venereal Disease? .... No Yes

MEDICATIONS:
List the medications you are taking: ______________________

List any over the-counter drugs or vitamins you take: ______________________

ALLERGIES:
Do you have any drug allergies? .... No Yes If yes, to what? ____________

What symptoms did you have? ______________________

FAMILY HISTORY

	If living: Age & Health Status	If deceased: Age @ death & cause
Father		
Mother		
Brother(s)		
Sister(s)		
Children		

Has any blood Relative had:

Cancer?... .... No Yes
Tuberculosis?..................... No Yes
Diabetes? .... No Yes
Heart Disease?................... No Yes
Stroke?.... .... No Yes
Seizures? .... No Yes
Bleeding problems? .... No Yes
Gout or Arthritis?................ No Yes
Glaucoma?......................... No Yes
Asthma or Hives?.............. No Yes

IMMUNIZATIONS: **Have you had the basic immunization series of:**

Tetanus and Diphtheria?........No Yes
Polio?....................................No Yes
Hepatitis A?...........................No Yes
Hepatitis B?...........................No Yes

Tetanus Booster in the past 10 years? ....No Yes
Measles, Mumps and Rubella (MMR).....................No Yes
Pneumonia Vaccine?...No Yes

SOCIAL HISTORY

Are you: Single Married Separated Divorced Widowed

Are you living with your husband, wife or partner? .. No Yes
Is your sex life satisfactory? .... No Yes
Do you have dependents at home? .... No Yes
Do you drink alcoholic beverages? .... No Yes, How much per day/week? ________________
Has anyone ever told you that you drink too much? No Yes
Do you now smoke? .... No Yes, How many?__________ How Long? _______
Did you ever smoke? .... No Yes, When did you stop? ____________________
Do you drink coffee, cola or tea? .... No Yes, How many Cups? ______________________
Do you exercise? .... No Yes, How much?__________________________
Have you used illicit drugs? .... No Yes, Which drugs and when? ________________
Have you ever been tested for HIV? .... No Yes, Would you like to be? ___________________
What is/was your occupation? ______________________________
Highest education obtained: _______________________________
Describe job stress: High Medium Low
Do you wear seat belts? .... No Yes

SCREENING TEST: (if applicable)
Have you ever had a:

Mammogram? .... No Yes, When was it last done?__________________
Bone Density Test? .... No Yes, When was it last done?__________________
Chest X-Ray? .... No Yes, When was it last done?__________________
EKG? .... No Yes, When was it last done?__________________
Exercise Stress Test? .... No Yes, When was it last done?__________________
Flexible Sigmoidoscopy? (colon cancer?) .... No Yes, When was it last done?__________________

SYSTEMS REVIEW: Do you have any of the following:

GENERAL:
Unexplained weight loss? .... No Yes
Chronic fevers? .... No Yes
Loss of appetite? .... No Yes

SKIN:
Skin Disease? .... No Yes
Jaundice? .... No Yes
Hives or Eczema? .... No Yes
Frequent infections or boils? .... No Yes
Abnormal moles? .... No Yes

HEAD-EYES-EARS-NOSE-THROAT:
Eye disease? .... No Yes
Do you wear glasses? .... No Yes
Blurred vision? .... No Yes
Glaucoma? .... No Yes
Frequent headaches? .... No Yes
Itchy eyes, runny nose, sneezing? .... No Yes
Frequent nosebleeds? .... No Yes
Chronic ringing in ear? .... No Yes
Sinus trouble? .... No Yes
Hearing loss or disease? .... No Yes
Dizziness or fainting spells? .... No Yes

NECK:
Stiffness? .... No Yes
Neck injury? .... No Yes
Enlarged neck glands? .... No Yes

RESPIRATORY:
Coughing / Spitting blood? .... No Yes
Chronic cough? .... No Yes
Asthma or wheezing? .... No Yes
Shortness or breath? .... No Yes
Difficulty walking 2 blocks? .... No Yes
Night sweats? .... No Yes
Skin tested for tuberculosis? .... No Yes

CARDIOVASCULAR:
Chest pain or angina? .... No Yes
Heart trouble? .... No Yes
Heart attack or Heart disease? .... No Yes
Shortness of breath
When laying down? .... No Yes
Wake up short of breath? .... No Yes
Heart murmurs? .... No Yes
Rapid or skipped heartbeats? .... No Yes
Swelling of hands, feet or ankles? .... No Yes

GASTROINTESTINAL:

Stomach or duodenal ulcer? .... No Yes
Heartburn or indigestion? .... No Yes
Sour taste in throat or mouth? .... No Yes
Use antacids or Tums often? .... No Yes
Intolerance to spicy foods,
coffee or alcohol? .... No Yes
Vomiting up blood? .... No Yes
Food/Liquid get stuck in your throat? .... No Yes
Gallbladder trouble? .... No Yes
Intolerance to greasy food? .... No Yes
Liver trouble? .... No Yes
Cramping, abdominal pain? .... No Yes
Chronic constipation? .... No Yes
Frequent diarrhea? .... No Yes
Uses laxatives often? .... No Yes
Recent change in bowel habits? .... No Yes
Bloody or black stools? .... No Yes
Hemorrhoids or piles? .... No Yes

GENITOURINARY:

Leak urine when cough or sneeze? .... No Yes
Frequent bladder/kidney infections? .... No Yes
Burning or painful urination? .... No Yes
Nighttime urination? .... No Yes
Feeling that you must
urinate immediately? .... No Yes
Bloody, pink or brown urine? .... No Yes
Kidney stones? .... No Yes

FOR MEN ONLY:

Difficulty starting urination? .... No Yes
Decrease in strength or urine stream? ...... No Yes
Discharge from penis? .... No Yes
Difficulty starting/maintaining erections? ... No Yes
Prostate Problems? .... No Yes

FOR WOME ONLY – GYNECOLOGICAL

Age when period started: ___ Years old
Frequency of periods: Every _____ days
Length of each period: ____________________
Number of pregnancies: ____________________
Number of deliveries: ____________________
Date of last Pap Smear: ____________________
Abnormal discharge or odor? .... No Yes
Extremely painful periods? .... No Yes
Painful intercourse? .... No Yes
Breast lumps or pain? .... No Yes

MUSCULOSKELETAL:

Significant arthritis? .... No Yes
Weakness in leg or arm? .... No Yes
Difficulty walking? .... No Yes
Pain in calves or buttock on walking? .... No Yes
Painful varicose veins? .... No Yes

NEUROLOGICAL:

Stroke? .... No Yes
Seizures? .... No Yes
Paralysis? .... No Yes
Numbness or tingling? .... No Yes
Loss of consciousness? .... No Yes

EMOTIONAL:

Do you sleep well? .... No Yes
Are you usually tired? .... No Yes
Are you often depressed? .... No Yes
Are you often anxious? .... No Yes
Do you feel hopeless or helpless? .... No Yes
Do you wish you were dead? .... No Yes
Do you worry often? .... No Yes
Do you have interest in friends or fun? ..... No Yes
Have you ever been advised to see a
psychiatrist? .... No Yes

HEMATOLOGICAL:

Anemia? .... No Yes
Unexplained bruising? .... No Yes
Excessive bleeding? .... No Yes

ENDORCRINE (hormone):

Hormone therapy? .... No Yes
Thyroid disease? .... No Yes
Intolerance to mildly warm or mildly cold
temperatures? .... No Yes
Change in texture of hair or skin? .... No Yes
Change in voice? .... No Yes
Crave large amounts of fluids? .... No Yes
Significant change in shoe size? .... No Yes
Severe fatigue? .... No Yes

Height ______________ Ideal Weight ________

____
Signature