

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: DOB:
 M F

PERSONAL HEALTH HISTORY (PAST MEDICAL HISTORY)

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

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

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	<input type="radio"/> Sedentary (No exercise) <input type="radio"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)									
	<input type="radio"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)									
	<input type="radio"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)									
Diet	Are you dieting?						<input type="radio"/>	Yes	<input type="radio"/>	No
	If yes, are you on a physician prescribed medical diet?						<input type="radio"/>	Yes	<input type="radio"/>	No
	# of meals you eat in an average day?									
Caffeine	<input type="radio"/> None	<input type="radio"/> Coffee	<input type="radio"/> Tea	<input type="radio"/> Cola						
	# of cups/cans per day?									
Alcohol	Do you drink alcohol?						<input type="radio"/>	Yes	<input type="radio"/>	No
	If yes, what kind?									
	How many drinks per week?									
Tobacco	Do you use tobacco?						<input type="radio"/>	Yes	<input type="radio"/>	No
	<input type="radio"/> Cigarettes – pks/day		<input type="radio"/> Chew	#/day	<input type="radio"/> Pipe	#/day	<input type="radio"/> Cigars #/day			
	<input type="radio"/> # of years	<input type="radio"/> Or year quit								
Drugs	Do you currently use recreational or street drugs?						<input type="radio"/>	Yes	<input type="radio"/>	No
	Have you ever given yourself street drugs with a needle?						<input type="radio"/>	Yes	<input type="radio"/>	No
Personal Safety	Do you live alone?						<input type="radio"/>	Yes	<input type="radio"/>	No
	Do you have frequent falls?						<input type="radio"/>	Yes	<input type="radio"/>	No
	Do you have vision or hearing loss?						<input type="radio"/>	Yes	<input type="radio"/>	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?						<input type="radio"/>	Yes	<input type="radio"/>	No
FAMILY HEALTH HISTORY										
Relation	AGE	AGE AT DEATH	SIGNIFICANT HEALTH PROBLEMS							
Father										
Mother										
Brothers										
Sisters										
MENTAL HEALTH QUESTIONNAIRE										
Is stress a major problem for you?						<input type="radio"/>	Yes	<input type="radio"/>	No	
Do you feel depressed?						<input type="radio"/>	Yes	<input type="radio"/>	No	
Do you panic when stressed?						<input type="radio"/>	Yes	<input type="radio"/>	No	
Do you have problems with eating or your appetite?						<input type="radio"/>	Yes	<input type="radio"/>	No	
Do you cry frequently?						<input type="radio"/>	Yes	<input type="radio"/>	No	
Have you ever seriously thought about hurting yourself?						<input type="radio"/>	Yes	<input type="radio"/>	No	
Do you have trouble sleeping?						<input type="radio"/>	Yes	<input type="radio"/>	No	
Have you ever been to a counselor?						<input type="radio"/>	Yes	<input type="radio"/>	No	
SCREENINGS (please indicate most recent date)										
Last Colonoscopy:	<input type="radio"/> Normal <input type="radio"/> Abnormal		Cholesterol Screening:	<input type="radio"/> Normal <input type="radio"/> Abnormal						
Test for blood in stools:	<input type="radio"/> Normal <input type="radio"/> Abnormal		Electrocardiogram:	<input type="radio"/> Normal <input type="radio"/> Abnormal						

PATIENT NAME: _____ DOB: _____

Review Of Systems (check all that apply to you)

CONSTITUTIONAL <input type="checkbox"/> Wt. loss or gain <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Chills EYES <input type="checkbox"/> Blurry vision <input type="checkbox"/> Double vision <input type="checkbox"/> Vision changes <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma ENT/MOUTH <input type="checkbox"/> Sinus problems <input type="checkbox"/> Runny nose <input type="checkbox"/> Tooth pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing ears <input type="checkbox"/> Gum pain <input type="checkbox"/> Gum bleeding <input type="checkbox"/> Swallowing difficulties <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear discharge ALLERGY/IMMUNO <input type="checkbox"/> Rashes/hives/welts <input type="checkbox"/> Itchiness <input type="checkbox"/> Allergic asthma/bronchitis	NEURO <input type="checkbox"/> Dizziness <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Headache <input type="checkbox"/> Lack of coordination <input type="checkbox"/> Balance problems <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness PSYCH <input type="checkbox"/> Depression <input type="checkbox"/> Mood swings <input type="checkbox"/> Memory problems <input type="checkbox"/> Anxiety ENDO <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Hair loss <input type="checkbox"/> Nail changes <input type="checkbox"/> Night sweats <input type="checkbox"/> Hot flashes SKIN <input type="checkbox"/> Skin rashes <input type="checkbox"/> Bruising <input type="checkbox"/> Changes in skin lesions <input type="checkbox"/> Wounds <input type="checkbox"/> Ulcers	GENITOURINARY <input type="checkbox"/> Burning urination <input type="checkbox"/> Excessive urination <input type="checkbox"/> Incontinence of urine <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent bladder/kidney infections <input type="checkbox"/> History of sexually transmitted disease GASTROINTESTINAL <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Incontinence of bowels <input type="checkbox"/> Blood in stools <input type="checkbox"/> Bloating <input type="checkbox"/> Poor appetite <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Nausea HEM/LYMPH <input type="checkbox"/> Bruising <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Lack of energy	RESPIRATORY <input type="checkbox"/> Frequent lung infections <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest tightness <input type="checkbox"/> Wheezing <input type="checkbox"/> Sleeping problems <input type="checkbox"/> Persistent cough <input type="checkbox"/> Asthma CARDIOVASCULAR <input type="checkbox"/> History of Rheumatic fever <input type="checkbox"/> Palpitations <input type="checkbox"/> Chest pain <input type="checkbox"/> Swelling hands <input type="checkbox"/> Swelling feet <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> High or low blood pressure MUSC/SKELETAL <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Muscle pains <input type="checkbox"/> Back pain <input type="checkbox"/> Pain during walking
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WOMEN ONLY

Age at menstruation:	Date of last PAP smear:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Number of pregnancies _____ Number of live births _____	Date of or age at last menstruation:	
Last Mammogram:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Bone Density Screening: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Experienced any recent breast tenderness, lumps, or nipple discharge?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last rectal exam?	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, # of times _____	
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Date of last PSA test (if any):	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal