



**HEALTH HISTORY QUESTIONNAIRE**

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

<b>Name</b> ( <i>Last, First, M.I.</i> ):	<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
<b>Primary Care Doctor:</b>	<b>Date of last physical exam:</b>	

**PERSONAL HEALTH HISTORY**

**List any medical problems that other doctors have diagnosed:**

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**Surgeries**

Year	Reason	Hospital

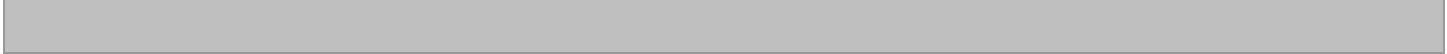
**Other hospitalizations**

Year	Reason	Hospital

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

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

Name the Drug	Strength	Frequency Taken



Allergies to medications:	
Name the Drug	Reaction You Had

**HEALTH HABITS AND PERSONAL SAFETY**

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<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
<b>Diet</b>	Are you dieting?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# Of meals you eat in an average day?			
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# Of cups/cans per day?			
<b>Alcohol</b>	Do you drink alcohol?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?			
	How many drinks per week?			
<b>Tobacco</b>	Do you use tobacco?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes - pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		

**FAMILY HEALTH HISTORY**

Family History:	
<b>Breast Cancer</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Melanoma</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Stroke</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>High Blood Pressure</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Heart Disease</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Diabetes</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Kidney Disease</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Depression</b>	<input type="checkbox"/> yes <input type="checkbox"/> no

**Past Medical History:**

<b>Heart Disease</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Asthma</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Arthritis</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>AIDS or HIV+</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Rheumatic Fever</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Stroke</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Anemia</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Hepatitis</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Tuberculosis</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Stomach Ulcer</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Diabetes</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Kidney Disease</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Cancer</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Thyroid Disease</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Glaucoma</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Bleeding tendency</b>	<input type="checkbox"/> yes <input type="checkbox"/> no

**WOMEN ONLY**

Age at onset of menstruation:

Date of last menstruation:

Period every \_\_\_ days

Are you pregnant or breastfeeding?  Yes  No

Have you had a D&C, hysterectomy, or Cesarean?  Yes  No

Number of pregnancies?

Experienced any recent breast tenderness, lumps, or nipple discharge?  Yes  No

Date of last mammogram?

**OTHER PROBLEMS**

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin rash	<input type="checkbox"/> Swollen lymph nodes	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Chronic diarrhea	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Rapid Heartbeat
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Energy level
<input type="checkbox"/> Depression	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Seizures	<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Weight
<input type="checkbox"/> Joint or muscle pain	<input type="checkbox"/> Chest Pain	

I verify that the above information is true and accurate to the best of my knowledge.

X \_\_\_\_\_

Signature of patient or parent if minor

Date

X \_\_\_\_\_

Physicians Signature