Health History Questionnaire

Name:___________________________ Age:____________ Date of Birth:_____________________

Address:__________________________ Male:___________ Female:_________________________

_________________________________ Today's Date:________________

Home Phone:_____________________ Business Phone:______________ Referred By:_____________________

Current Complaint/Illness (please describe):____

____

____

Past Medical History:

Major Childhood Illnesses	Age
______________________	__________
______________________	__________
______________________	__________

Adult Medical Illnesses	Date
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________

Previous Surgeries	Date
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________

Ever had blood transfusions? __________

Social History:

Married _______ Single ________ Separated _________

Widowed______

Children	Age
______________________	__________
______________________	__________
______________________	__________

Education:

Elementary– Years: _______________

High School– Years: _______________

College - Years: _______________

Occupation________________________

	Amount	Duration
Cigarettes	____________	____________
Pipe/Cigar	____________	____________
Chewing	____________	____________
Alcohol Consumption	____________	____________

Medical Allergies	Reaction
______________________	__________
______________________	__________
______________________	__________

Current Medications	Dosage
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________

Place an (X) next to any of the following tests you have had <u>and give date when you last had them:</u>

Chest X-Ray	__________	__________
Electrocardiogram	__________	__________
Treadmill	__________	__________
Upper GI x-ray	__________	__________
Colon x-ray	__________	__________
Flexible Sigmoidscopy	__________	__________
Mammogram	__________	__________
Pap Smear	__________	__________
T.B. Test	__________	__________
Cholesterol	__________	__________

Family History:

		Health		List any	If deceased,
	Age	Good	Poor	Illnesses	cause of death
Father	_____	_____	_____	_________	_________
Mother	_____	_____	_____	_________	_________
Brother	_____	_____	_____	_________	_________
Brother	_____	_____	_____	_________	_________
Sister	_____	_____	_____	_________	_________

Review of Symptoms—Place an (X) before signs or symptoms which you frequently have had or presently have.

General
- ______ Fever
- ______ Night Sweats
- ______ Fatigue Easily
- ______ Weight Loss (list pounds)
- ______ Weight Gain (list pounds)
- ______ Recent loss of appetite
- ______ Shaking chills
- ______ Excessive thirst

Neurological System
- ______ Lightheadedness
- ______ Fainting Spell
- ______ Convulsions
- ______ Tremors
- ______ Sudden periodic loss of vision
- ______ Sudden fall to floor without loss of consciousness
- ______ Memory loss

Musculoskeletal
- ______ Painful joints
- ______ Swollen joints
- ______ Back pains
- ______ Shoulder pains
- ______ Generalized muscle aches
- ______ Swollen/painful big toe
- ______ Morning stiffness of joints

Eyes
- ______ Eyesight worsening
- ______ Sees double
- ______ Cataracts

Ears
- ______ Hearing Difficulties
- ______ Buzzing in the ears

Mouth
- ______ Dental Problems
- ______ Easy bleeding gums

Nose
- ______ Congestion (frequently)
- ______ Nose bleeds (frequently)

Head
- ______ Frequent Headaches
- ______ Painful or tender
- ______ Over sinuses

Neck
- ______ Neck Pains
- ______ Neck lumps or swelling
- ______ Stiffness of the neck

Throat
- ______ Hoarse voice

Lungs
- ______ Wheezing
- ______ Shortness of breath (which awakens you at night)
- ______ Shortness of breath (which Rapidly develops upon walking)
- ______ Cough with sputum
- ______ Cough without sputum
- ______ Coughing up blood
- ______ History of tuberculosis
- ______ Pain with breathing

Skin
- ______ Itching of skin
- ______ Bruise easily

Special Problems or Symptoms:______________________

____

____

____

Heart
- ______ High blood pressure
- ______ Attacks of racing heart beats
- ______ Chest Pains
- ______ Dizzy Spells
- ______ Swollen feet or ankles
- ______ Leg cramps produced by walking
- ______ History of heart murmur

Digestive System
- ______ Difficulty swallowing
- ______ Pain on swallowing
- ______ Heartburn
- ______ Stomach pains
- ______ Diarrhea
- ______ Vomiting
- ______ Vomiting up blood or coffee Ground colored material
- ______ Black stools
- ______ Constipation
- ______ Yellow jaundice

Urinary Tract
- ______ Frequent urination
- ______ Get up at night to urinate
- ______ Wet pants on coughing/straining
- ______ Burning upon urination
- ______ History of kidney stones

Male Genital
- ______ Difficulty starting urination
- ______ Weak stream
- ______ Discharge on penis
- ______ Sores on penis
- ______ History of venereal disease
- ______ Difficulty obtaining erection
- ______ Painful testicles
- ______ Swelling or lumps on testicles
- ______ Prostate trouble

Female Genital
- ______ Vaginal discharge
- ______ History of venereal disease
- ______ Vaginal itching
- ______ List age onset of menstrual cycle
- ______ If menstruation has ceased, list age at which it stopped
- ______ Menstrual problems
- ______ Break through bleeding
- ______ Excessively heavy bleeding
- ______ Excessive light bleeding
- ______ Premenstrual tension
- ______ Take birth control pills

Breasts (Male and Female)
- ______ Soreness of breasts
- ______ Discharge from breasts
- ______ Recent enlargement
- ______ History of breast cancer

Ankle/Foot
- ______ Foot/Ankle injury
- ______ Foot/Ankle pain
- ______ Foot/Toe deformity
- ______ Bunions/hammer toes

Sleep Problems
- ______ Loud snoring or problems Breathing while sleeping
- ______ Excessively tired during the day
- ______ Difficulty falling or staying asleep
- ______ Abnormal behavior while asleep