HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, MI) _____ Date _____

Medical Allergies	**Yes**	**No**	**Don't Know**
Are you allergic to the dye used in X-rays?			
Are you allergic to latex?			
Are you allergic to medications (for example, Penicillin)?			

Medication	Date of Reaction	Type of Allergic Reaction

Medications: List all medications you are now taking (including vitamins and nonprescription drugs) and doses starting with most recent. Bring all medications to every visit.

Medication	Date Prescribed	Dosage	Frequency

Medical History: List all illnesses or conditions (for example, diabetes, heart disease, cancer, high blood pressure) starting with most recent.

Illness/Condition	Date Diagnosed	Treatment	Physician

Hospitalizations & Operations: List all hospitalizations and operations starting with most recent.

Reason for Hospitalization	Date(s) Hospitalized	Hospital	Physician

_____ Patient's Initials

Genitourinary: Women	**Yes**	**No**	**Don't Know**
Age started menstruating:			
Date of last menstrual period:			
Age stopped menstruating:			
Date of your last pap smear:			
Still menstruating			
Painful intercourse			
Bleeding following intercourse			
Endometriosis			
Did your mother take estrogen when pregnant with you?			
Pregnant now			
Number of pregnancies:			
Number of children:			
Number of miscarriages:			
Age at first pregnancy:			

Family Health History

Relative	Age	Alive		Hypertension	Heart disease	Stroke	High Cholesterol	Lung Disease
		Yes	No					

Other illnesses that "run" in your family:

_____

_____

_____

Social History	**Yes**	**No**	**Don't Know**
Marital status: ___Married ___Single ___Separated ___Divorced ___Widowed			
Number of dependents at home:			
Education: ___Grade school ___High school ___College ___Other:			

Occupation/Work History & Environmental Exposure	**Yes**	**No**	**Don't Know**
What is your current occupation?			
Did you previously have a different occupation?			

Tobacco, Alcohol & Other Substance Use	**Yes**	**No**	**Don't Know**
Do you use? ____cigarettes ____cigars ____pipe ____chewing tobacco ____snuff (check all that apply)			
How much do you use per day? Number of years?			
Have you been exposed to secondhand smoke at home or work?			
Do you drink alcoholic beverages regularly?			
Do you drink alcoholic beverages on social occasions, only?			
Has alcohol ever interfered with your personal/professional life?			
Did you, or do you, use marijuana?			
Have you have used cocaine, heroin or other illegal substances?			

_____ Patient's Initials

Review of Systems

Eyes	**Yes**	**No**	**Don't Know**
Lost vision			
Wear glasses			
Cataracts			
Glaucoma			
Ears	**Yes**	**No**	**Don't Know**
Lost hearing			
Ringing in your ears			
Sinus trouble			
Nosebleeds			
Mouth	**Yes**	**No**	**Don't Know**
Dental problems			
Wears dentures			
Sore tongue			
Pain	**Level**		
Average pain most days	0 1 2 3 4 5 6 7 8 9 10 (none/low) (worst)		
Where does it hurt?			
Staying this same or getting worse? __Same __Worse			
What are you taking for it?			
Does this help?			
Fever			
Skin	**Yes**	**No**	**Don't Know**
Lesion removed			
Bleeding skin lesion			
Skin cancer			
Chronic rash			
Breast	**Yes**	**No**	**Don't Know**
Breast biopsy			
Breast cancer			
Nipple discharge			
Breast lumps			
Cystic breast disease			
Breast infection			
Mammogram			Date:
Hormone replacement therapy			Date:
Breastfed any children			
If "yes," how long in total months:			
Lungs	**Yes**	**No**	**Don't Know**
Cough every day			
Cough, produce sputum (phlegm) most days			
Blood in your sputum			
Pneumonia			
Bronchitis			
Emphysema			
Pleurisy			
Tuberculosis			
Asthma			
Short of breath with Activity			
Short of breath at rest			
Frequent colds			
Heart, Blood Vessels	**Yes**	**No**	**Don't Know**
Chest pain (angina)			
Chest pressure			
Heart attack			
Short of breath at night			
Heart murmur			
Rapid heartbeat that required treatment			
Swollen ankles			
Leg cramps at night			
Leg cramps when walking			
Rheumatic fever			
Congenital heart disease			
Hematologic	**Yes**	**No**	**Don't Know**
Blood transfusion			
Rejected as blood donor			
Bruise or bleed easily			
Anemic			
Swollen glands			
Gastrointestinal	**Yes**	**No**	**Don't Know**
Loss of appetite			
Recent weight change			
If yes, amount: _____Loss _____Gain			
Excess saliva			
Heartburn			
Ulcer			
Endoscopy (upper GI, colonoscopy, etc.)			
Neurological	**Yes**	**No**	**Don't Know**
Dominant hand: _____ Right _____ Left			
Headaches			
Seizure			
Double vision			
Blurred vision			
Weakness in extremity			
Numbness			
Stroke			
Migraine headaches			
Forgetfulness			
Confusion			

Genitourinary: Men	**Yes**	**No**	**Don't Know**
Difficulty starting/stopping urination			
Sexual performance problems			
Elevated prostate blood test			

Mental Health	**Yes**	**No**	**Don't Know**
Is stress a major problem?			
Do you feel depressed?			
Do you panic when stressed?			
Do you have problems with eating or your appetite?			
Do you cry frequently?			
Have you ever attempted suicide?			
Have you ever seriously thought about hurting yourself?			
Do you have trouble sleeping?			
Have you ever been to a counselor?			

_____

Patient Signature

_____ Provider's Initials