Health History Questionnaire

NAME_____ DATE_____

DATE OF BIRTH_____ REFERRING DOCTOR_____

REASON FOR SEEING THE DOCTOR_____

_____

WHEN DID IT START?_____

WHAT MAKES IT BETTER?_____

WHAT MAKES IT WORSE?_____

MEDICAL HISTORY

DO YOU HAVE DIABETES?.....Yes No
DO YOU HAVE HIGH BLOOD PRESSURE? Yes No
DO YOU HAVE HEART DISEASE?..... Yes No
DO YOU HAVE LUNG DISEASE?..... Yes No
OTHER?..... Yes No

If yes please explain_____

_____

_____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 6 MONTHS?_____

If yes please explain_____

_____

ALLERGIES : _____

Please List All Your Medications (incl name, dose and frequency):

_____

_____

_____

_____

_____

_____
Physician Signature

SURGICAL HISTORY

Please list any surgeries and the year which they were performed

_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Do you smoke? Yes No If yes, number of packs per day_____
If yes, at what age did you start_____

Do you consume alcohol? Circle one: Never Rarely Moderately Daily
What is your occupation?_____

FAMILY HISTORY

If living, age & any medical illnesses If deceased, age & cause of death

MOTHER_____
FATHER_____
SIBLINGS_____
_____
_____

HAS ANY RELATIVE EVER HAD: (CIRCLE THE ONES THAT APPLY)

Alcoholism Bleeding tendency Cancer Diabetes Heart disease
Stroke Seizures Ulcer disease Liver disease High blood pressure

REVIEW OF SYSTEMS

If You have any of the following, please circle YES.

GENERAL
Recent weight change?..... Yes No
If Yes, how much?_____

SKIN
Itching..... Yes No
Jaundice..... Yes No
Hives..... Yes No
Infection or boils..... Yes No
Abnormal pigmentations..... Yes No

HEAD, EYES,EARS,NOSE, THROAT
Eye disease or injury..... Yes No
Headaches..... Yes No
Glaucoma..... Yes No
Double vision..... Yes No
Frequent nosebleeds..... Yes No
Sinus infections..... Yes No
Ear disease..... Yes No
Impaired hearing..... Yes No
Dizziness..... Yes No

NECK
Stiffness..... Yes No
Enlarged glands..... Yes No

RESPIRATORY
Frequent colds..... Yes No
Coughing up blood..... Yes No
Asthma or wheezing..... Yes No
Difficulty breathing..... Yes No
Lung disease..... Yes No
Pleurisy or pneumonia..... Yes No

CARDIOVASCULAR
Chest pain or angina..... Yes No
Shortness of breath..... Yes No
Difficulty walking two blocks or more..... Yes No
Heart disease..... Yes No
High or low blood pressure ..... Yes No
Swelling of the ankles..... Yes No
Heart murmur..... Yes No
Racing heart beat..... Yes No
Stroke..... Yes No

HEMATOLOGIC
Slow to heal..... Yes No
Blood diseases..... Yes No
Anemia..... Yes No
Blood clots..... Yes No
Bruise easily..... Yes No

GENITOURINARY
Loss of urine..... Yes No
Night time urination..... Yes No
Frequent urination..... Yes No
Straining to urinate..... Yes No
Pain or burning urination Yes No
Blood in urine..... Yes No

GYNECOLOGICAL (if applicable)
Are you pregnant..... Yes No
Number of pregnancies_____
Number of children_____
Last menstrual period_____
Frequent periods..... Yes No

NEURO-PSYCHIATRIC
Are you receiving any psychiatric therapy..... Yes No
Fainting spells..... Yes No
Convulsions..... Yes No
Sleep difficulties..... Yes No
Depression..... Yes No
Do you cry often..... Yes No
Have you ever considered suicide..... Yes No
Used any hard drugs..... Yes No

ENDOCRINE
Thyroid disease..... Yes No
Dry skin..... Yes No
High or low blood sugar. Yes No
Do you take insulin..... Yes No
Tire easily..... Yes No

GASTROINTESTINAL AND LIVER HISTORY

Have you ever had any of the following: (PLEASE CIRCLE ANY THAT APPLY)

Jaundice Liver trouble Hepatitis Liver cirrhosis Parasites
Infectious dysentery Colitits Diveticulitis Gallbladder disease
Gallstones Enlarged spleen Injury to you intestinal or stomach organs

Does food stick when you swallow.....	Yes	No
Do you ever have pain when swallowing.....	Yes	No
For how long _____		
How often does this happen _____		
Does this happen only with solid foods.....	Yes	No
Does this happen only with liquids.....	Yes	No
Are you troubled by heartburn.....	Yes	No
Do you frequently vomit.....	Yes	No
Have you vomited blood.....	Yes	No
Have you had a change in your bowel habits..	Yes	No
Constipation.....	Yes	No
Diarrhea.....	Yes	No
Have you had any bloody stools.....	Yes	No
Have you had any black stools	Yes	No
Do you have any relatives that have colon polyps.....	Yes	No
Do you have any relatives that have colon or rectal cancer.....	Yes	No
Do you have any relatives with ulcerative colitis or Crohn's disease.....	Yes	No
Have you ever had any blood transfusions....	Yes	No
Have you ever had hepatitis.....	Yes	No
Do you have any tattoos.....	Yes	No
Are you worried that you could have AIDS...	Yes	No

Is there any other information that you feel may be helpful to the doctor?