

## 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	Medical Allergies	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Adult Medical Illnesses	Date	Current Medications	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous Surgeries	Date		
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ever have 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	_____	_____

Place an (X) next to any of the following tests you have had & give date when you last had them:

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 illnesses	If deceased, cause of death
	Age	Good	Poor		
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Provider: \_\_\_\_\_

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

General	<input type="checkbox"/> Fever	Heart	<input type="checkbox"/> High blood pressure
	<input type="checkbox"/> Night Sweats		<input type="checkbox"/> Attacks of racing heart beat
	<input type="checkbox"/> Fatigue easily		<input type="checkbox"/> Chest pains
	<input type="checkbox"/> Weight loss (list pounds)		<input type="checkbox"/> Dizzy spells
	<input type="checkbox"/> Weight gain (list pounds)		<input type="checkbox"/> Swollen feet or ankles
	<input type="checkbox"/> Recent loss of appetite		<input type="checkbox"/> Leg cramps produced by walking
	<input type="checkbox"/> Shaking chills		<input type="checkbox"/> History of heart murmur
	<input type="checkbox"/> Excessive thirst		
Neurological Syst.	<input type="checkbox"/> Lightheadedness	Digestive Syst.	<input type="checkbox"/> Difficulty swallowing
	<input type="checkbox"/> Fainting Spell		<input type="checkbox"/> Pain on swallowing
	<input type="checkbox"/> Convulsions		<input type="checkbox"/> Heartburn
	<input type="checkbox"/> Tremors		<input type="checkbox"/> Stomach pains
	<input type="checkbox"/> Sudden periodic loss of vision		<input type="checkbox"/> Diarrhea
	<input type="checkbox"/> Sudden fall to floor without loss of consciousness		<input type="checkbox"/> Vomiting
	<input type="checkbox"/> Memory loss		<input type="checkbox"/> Vomiting up blood or coffee ground colored material
Musculoskeletal	<input type="checkbox"/> Painful joints		<input type="checkbox"/> Black stools
	<input type="checkbox"/> Swollen joints		<input type="checkbox"/> Constipation
	<input type="checkbox"/> Back pains		<input type="checkbox"/> Yellow jaundice
	<input type="checkbox"/> Shoulder pains	Urinary Tract	<input type="checkbox"/> Frequent urination
	<input type="checkbox"/> Generalized muscle aches		<input type="checkbox"/> Get up at night to urinate
	<input type="checkbox"/> Swollen/painful big toe		<input type="checkbox"/> Wet pants on coughing/straining
	<input type="checkbox"/> Morning stiffness of joints		<input type="checkbox"/> Burning upon urination
Eyes	<input type="checkbox"/> Eyesight worsening	Male Genital	<input type="checkbox"/> History of kidney stones
	<input type="checkbox"/> Sees double		<input type="checkbox"/> Difficulty starting urination
	<input type="checkbox"/> Cataracts		<input type="checkbox"/> Weak stream
Ears	<input type="checkbox"/> Hearing difficulties		<input type="checkbox"/> Discharge from penis
	<input type="checkbox"/> Buzzing in the ears		<input type="checkbox"/> Sores on penis
Mouth	<input type="checkbox"/> Dental problems		<input type="checkbox"/> History of venereal disease
	<input type="checkbox"/> Easy bleeding of gums		<input type="checkbox"/> Difficulty obtaining erection
Nose	<input type="checkbox"/> Congestion (frequently)		<input type="checkbox"/> Painful testicles
	<input type="checkbox"/> Nose bleeds (frequently)		<input type="checkbox"/> Swelling or lumps on testicles
Head	<input type="checkbox"/> Frequent headaches	Female Genital	<input type="checkbox"/> Prostate trouble
	<input type="checkbox"/> Painful or tender		<input type="checkbox"/> Vaginal discharge
	<input type="checkbox"/> Over sinuses		<input type="checkbox"/> History of venereal disease
Neck	<input type="checkbox"/> Neck pains		<input type="checkbox"/> Vaginal itching
	<input type="checkbox"/> Neck lumps or swelling		<input type="checkbox"/> List age onset of menstrual cycle
	<input type="checkbox"/> Stiffness of the neck		<input type="checkbox"/> If menstruation has ceased, list age at which it stopped
Throat	<input type="checkbox"/> Hoarse voice		<input type="checkbox"/> Menstrual problems
Lungs	<input type="checkbox"/> Wheezing		<input type="checkbox"/> Break through bleeding
	<input type="checkbox"/> Shortness of breath (which awakens you at night)	Breasts (Male & Female)	<input type="checkbox"/> Excessively heavy bleeding
	<input type="checkbox"/> Shortness of breath (which rapidly develops upon walking)		<input type="checkbox"/> Excessively light bleeding
	<input type="checkbox"/> Cough with sputum		<input type="checkbox"/> Premenstrual tension
	<input type="checkbox"/> Cough without sputum		<input type="checkbox"/> Take birth control pills
	<input type="checkbox"/> Coughing up blood	Ankle/Foot	<input type="checkbox"/> Soreness of breasts
	<input type="checkbox"/> History of tuberculosis		<input type="checkbox"/> Discharge from breasts
	<input type="checkbox"/> Pain with breathing		<input type="checkbox"/> Recent enlargement
			<input type="checkbox"/> History of breast cancer
		Sleep Problems	<input type="checkbox"/> Foot/ankle injury
			<input type="checkbox"/> Foot/ankle pain
Skin	<input type="checkbox"/> Itching of skin		<input type="checkbox"/> Foot/toe deformity
	<input type="checkbox"/> Bruise easily		<input type="checkbox"/> Bunions/hammer toes

Special Problems or Symptoms: \_\_\_\_\_