Health History Questionnaire

Save yourself some time before your first visit with us. Simply print this form and fill it out. Then bring the filled out form with you when you visit us so you won't need to do this when you arrive.

Date: ____/____/20____

Last Name:___________________________ First Name:_______________________ Initial:____

Sex: ___Male ___Female Race:________________ Language Spoken: __________________

Education

Have you ever had any learning disabilities? ___No ___Yes

Highest level of education? ____

Medications

Please list the name and dosages of any medication that you are taking.

Medication	Dosage	Frequency
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________

Note any non-prescription medications that you routinely take:

Please list any nutritional supplements, herbal remedies, or "natural products" that you are taking:

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Allergy History

Have you ever had an allergic reaction to medicine, food, or any other substance? If yes, please describe below.

Substance	Reaction	Year
___	___	___
___	___	___
___	___	___
___	___	___

Medical History

Have you had any serious injuries? ___No ___Yes

Head

Illness	Relative	Myself	Year
Migraine Headaches	___	___	___
Head Injury	___	___	___
Stroke	___	___	___
Epilepsy, Seizures	___	___	___
Eyes / Ears			
Glaucoma	___	___	___
Other Eye Problems	___	___	___
Deafness	___	___	___
Lungs			
Bronchitis	___	___	___
Emphysema	___	___	___
Pneumonia	___	___	___
Asthma	___	___	___
Tuberculosis (TB)	___	___	___

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Cardiovascular

Illness	Relative	Myself	Year
High Blood	______________________________	_______	____________
Pressure	______________________________	_______	____________
Heart Attack	______________________________	_______	____________
High Cholesterol	______________________________	_______	____________
Poor Circulation	______________________________	_______	____________
Bleeding Tendency	______________________________	_______	____________
Blood Clots Anemia	______________________________	_______	____________
Endocrine			
Diabetes	______________________________	_______	____________
Thyroid (high or low)	______________________________	_______	____________
Cancer			
Breast	______________________________	_______	____________
Ovarian	______________________________	_______	____________
Colon	______________________________	_______	____________
Prostate	______________________________	_______	____________
Other	______________________________	_______	____________
Stomach / Digestion			
Ulcer	______________________________	_______	____________
Diverticulosis	______________________________	_______	____________
Colitis	______________________________	_______	____________
Crohns Disease	______________________________	_______	____________
Yellow Jaundice	______________________________	_______	____________
Intestinal Malabsorption	______________________________	_______	____________
Spleen Enlargement	______________________________	_______	____________

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Stomach / Digestion (continued)

Illness	Relative	Myself	Year
Liver Trouble / Hepatitis			
Gallbladder Trouble			
Hernia			
Hemorrhoids			
Inflammatory Bowel Disease			
Urinary			
Kidney Disease			
Renal Failure			
Bladder Disease			
Prostate Problems			
Kidney Stones			
Illnesses			
Chicken Pox			
Measles			
Mononucleosis			
Hepatitis			
Rheumatic Fever			
Other			
Arthritis			
Psoriasis			
Metal Illness / Depression			
Drug Addiction			
Alcoholism			
AIDS / HIV			
Venereal Disease			

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Immunization History

Enter the year you last received any of the following immunizations. If you have not received an immunization, leave the field blank.

Chicken Pox:___________ Measles: ___________ Tetanus:___________
Flu "Shots":___________ Mumps: ___________ Tuberculosis (TB): __________
Hepatitis A:___________ Pneumonia: ___________
Hepatitis B:___________ Rubella: ___________

Surgical History

Have you had any surgical procedures? ___No ___Yes

If yes, please describe the surgical procedure, provide the approximate date, name of the surgeon and the hospital.

Surgical Procedure	Date	Surgeon	Hospital
___________________________________	___________	_______________________	_________________
___________________________________	___________	_______________________	_________________
___________________________________	___________	_______________________	_________________
___________________________________	___________	_______________________	_________________
___________________________________	___________	_______________________	_________________

Personal Health History

Health Maintenance

Have you ever had a sigmoidoscopy? ___No ___Yes Date: ____/____/______

Have you ever had a colonoscopy? ___No ___Yes Date: ____/____/______

Female only:

Have you ever had a mammogram? ___No ___Yes Date: ____/____/______

Do you have a history of suspicious mammograms? ___No ___Yes

Do you examine your breasts monthly? ___No ___Yes

Have you ever found a lump? ___No ___Yes Indicate Location:_____________________

Did you find the lump by: ___Self exam ___Medical exam ___Mammogram

Any abnormal PAPs? ___No ___Yes Date of last PAP smear: ____/____/______

Do you live:

___Alone ___With Relatives ___With Spouse
___With Friends ___With Significant Other ___With Spouse/Children

Health History Questionnaire

Yearly System Review

Have you recently experienced any of the following? Check the symptoms that you have recently experienced. Please describe any pertinent details related to the items you check off at the end of this section in the area provided.

Constitutional Symptoms

___Fatigue

___Fever

___Good general health lately

___Headaches

___Recent weight change

Eyes

___Blurred or double vision

___Eye disease or injury

___Wear glasses / contact lenses

Ears / Nose / Mouth / Throat

___Bad breath or bad taste

___Bleeding Gums

___Chronic sinus problem or rhinitis

___Difficulty chewing or swallowing

___Earaches or drainage

___Hearing loss or ringing

___Mouth sores

___Nose Bleeds

___Sore throat or voice change

___Swollen glands in neck

Cardiovascular

___Chest pain or angina pectoris

___Dizziness

___Heart trouble

___Palpitation

___Shortness of breath while walking or lying flat

___Swelling of feet, ankles or hands

Respiratory

___Asthma or wheezing

___Chronic or frequent coughs

___On Oxygen

___Shortness of breath

___Spitting up blood

Gastrointestinal

___Abdominal pain or heartburn

___Anal discharge

___Change in bowel movements

___Frequent diarrhea

___Laxative usage

___Loss of appetite

___Nausea or vomiting

___Painful bowel movements or constipation

___Rectal bleeding or blood in stool

Hematologic / Lymphatic

___Easy bruise-ability

___Enlarged glands

___Past transfusion

___Phlebitis

___Night Sweats

___Slow to heal after cuts

___Thrombocytosis or absolute neurophilia in a blood test

Musculoskeletal

___Back pain

___Cold extremities

___Difficulty in Walking

___Joint pain

___Joint stiffness or swelling

___Muscle pain or cramps

___Weakness of muscles or joints

Genitourinary

___Blood in urine

___Burning or painful urination

___Change in force of strain when urinating

___Frequent urination

___Incontinence or dribbling

___Sexual difficulty

Health History Questionnaire

Gender Specific

Male

___Penile discharge

___Testicle pain

Female

___Irregular periods

___Pain with periods

___Vaginal discharge

Number of pregnancies: _________

Number of miscarriages: _________

Date of last menstrual period: ____/____/______

Age at first menstrual period _________

Birth control use at present: ___No ___Yes

Types _____________________________

History of birth control / estrogen use: ___No ___Yes

Type: _________________________________

For how long _______________________

Age at first pregnancy: _________

Age at last pregnancy: _________

Problems with pregnancy: ___No ___Yes

Describe:

Integumentary (skin, breast)

___Breast pain (Left___ or Right___)

___Breast Swelling

___Change in skin color

___Change in hair or nails

___Nipple discharge

___Rash or itching

___Skin moles / pigment changes

___Varicose veins

Neurological

___Frequent or recurring headaches

___Light headed or dizzy

___Numbness or tingling sensations

___Paralysis

___Tremors

Psychiatric

___Depression

___Insomnia

___Memory loss or confusion

___Nervousness

Endocrine

___Change in hat or glove size

___Excessive thirst or urination

___Heat or cold intolerance

___Skin becoming dryer

Describe any details of symptoms you checked off above

(if pertinent):

Personal Information

Number of people living in your household? _________

Occupation? ____

How many hours per week do you spend at your job? ________________

What are your hobbies and interests? ____

Health History Questionnaire

Personal Information (continued)

Are you or have you been exposed to hazardous materials? ___No ___Yes

If yes, what kind? ____

Are you or have you been experienced any high voltage electrical exposure? ___No ___Yes

If yes, what kind? ____

Do you exercise regularly? ___No ___Yes, what kind? ____

Are you on a special diet? ___No ___Yes, what kind? ____

Do you smoke? ___No ___Yes Cigarettes per day: _______

Are you an ex-smoker? ___No ___Yes, Number of packs per day: _______

Date you quit smoking: ____/____/______

Do you drink alcoholic beverages? ___No ___Yes Ounces per day: _______

Please provide additional details if necessary:

Are there any cultural or religious issues that may affect your health care? ___No ___Yes
If yes, please explain:

Have you ever been the victim of sexual, emotional, physical abuse or neglect? ___No ___Yes

How many hours of sleep per day or night do you get? ________

Do you feel you need nutritional counseling or education by a dietician? ___No ___Yes

Do you have enough food to eat each day? ___No ___Yes

Do you have an eating disorder? ___No ___Yes

Do you drink coffee, tea, or cola? ___No ___Yes Cups per day: _______

Do you use drugs not prescribed by a physician and / or not purchased in a drug store? ___No ___Yes

Do you wear sunblock? ___No ___Yes

Do you need assistance in performing daily activities? ___No ___Yes

Do you have a living will? ___No ___Yes

Do you have a durable power of attorney for health care? ___No ___Yes

Recent viral or other infection? ___No ___Yes, please describe: