Health History Questionnaire

Name: ____________________________________________

D.O.B: ____________________________________________

Past Medical History (please check all that apply):
()- Alcoholism
()- Anemia
()- Anesthesia Complications
()- Arthritis
()- Anxiety/Panic
()- Birth Defects
()- Blood Pressure
()- Blood Transfusion
()- Cancer
()
()- Cholesterol
()- Depression
()- Diabetes
()- Growth / Development
()- Gastrointestinal Problems
()- Heart Problems
()- HIV/AIDS
()- Liver Problems
()
()- Kidney Problems
()- Osteoporosis
()- Osteoporosis/Osteopenia
()- Seizure
()- Stroke
()- Severe Allergies
()
()
()

Past Surgical History (please check all that apply):
()- Appendectomy
()- Amputation
()- Back Surgery
()- Cardiac, Bypass
()- Cardiac, Valve
()- Cardiac, Defibrillator
()
()- Carotid Endarterectomy
()- Cataract
()- Cholecystectomy
()- Colon Resection
()- Lung Resection
()- Gastric Bypass
()
()- Hemorrhoidectomy
()- Hernia Repair
()- Hip Replacement
()- Hysterectomy
()- Knee Replacement
()- Gastric Lap-Band
()
()- Mastectomy
()- Parathyroidectomy
()- Prostate Surgery
()- Rotator Cuff Repair
()- Tonsillectomy
()- Knee Arthroscopy
()- Thyroidectomy
()
()
()

() Other: ____________________________________________
Family History (please check all that apply):

() Alcoholism  () Diabetes  () Thyroid Conditions
() Asthma  () Heart Disease  () No Significant Family History
() Blood Clots  () Hypertension  () Other:
() Cancer  () High Cholesterol  ____________________________
() Depression  () Osteoporosis  ____________________________

Social History:

Smoking:  () Currently Smokes  () Former Smoker - Year Quit: __________
() Never Smoked
Passive smoke exposure:  () Yes  () No
Alcohol Use:  () Yes  () No  Drug Use: () Yes  () No  HIV High Risk:  () Yes  () No
Regular Exercise:  () Yes  () No
Marital Status: ____________________________  Living Arrangements: ____________________________
History of Domestic Abuse:  () Yes  () No
Religious Beliefs Affecting Care: ____________________________________________

Review of Systems (please check all that apply):

General:  () Fever  () Chills  () Sweats  () Loss of Appetite  () Weight Loss  () Malaise  () Fatigue
Eyes:  () Vision Loss  () Double Vision  () Eye Irritation  () Blurring  () Pain  () Discharge  () Halos
() Light Sensitivity
ENT:  () Ringing in Ears  () Ear Discharge  () Earache  () Decreased Hearing  () Nasal Congestion
() Nosebleed  () Difficulty Swallowing  () Hoarseness  () Sore Throat
CV:  () Difficulty Breathing at Night  () Near Fainting/Fainting  () Chest Pain  () Chest Discomfort/Pressure
() Racing/Skipping Heart Beats  () Fatigue  () Shortness of Breath with Exertion  () Palpitation
() Swelling Hands/Feet  () Difficulty Breathing while Lying Down  () Leg Cramps with Exertion
Resp: () Sleep Disturbance due to Breathing () Cough () Shortness of Breath () Coughing up Blood
() Wheezing () Excessive Sputum () Excessive Snoring

GI: () Excessive Appetite () Loss of Appetite () Indigestion () Vomiting Blood () Nausea () Vomiting Blood
() Yellowish Skin/Eyes () Gas () Abdominal Pain () Abdominal Bloating () Hemorrhoids () Diarrhea
() Constipation () Change in Bowel Habits () Dark or Tarry Stools () Bloody Stools

GU: () Dysuria (Painful urination) () Hematuria (Bloody Urine) () Discharge
() Frequency (Excessive Frequent Urination) () Nocturia (Excess Night Urine)
() Hesitancy (Difficulty starting urination, inability to empty, need to empty with urgency)
() Incontinence (loss of urine control) () Genital Sores () Decreased Libido () Erectile Dysfunction
() Excessive Heavy Periods () Missed Periods

MS: () Muscle Cramps () Joint Pain () Joint Swelling () Back Pain () Stiffness () Muscle Weakness
() Arthritis () Gout () Loss of Strength () Muscle Aches () Restless Leg

Derm: () Excessive Sweating () Suspicious Lesions () Dryness () Poor Healing () Unusual Hair Distribution
() Skin Cancer () Itching () Flushing () Rash () Changes in Skin Color

Neuro: () Difficulty with Concentration () Poor Balance () Headaches () Numbness () Tingling
() Inability to Speak () Brief Paralysis () Visual Disturbances () Seizures () Weakness
() Spinning Sensation/Vertigo () Tremors () Fainting () Excessive Daytime Sleeping () Memory Loss

Psych: () Anxiety () Suicide Thoughts () Depression () Thoughts of Violence
() Frightening Visions or Sounds (Hallucinations)

Endo: () Excessive Hunger () Cold Intolerance () Heat Intolerance () Excessive Urination
() Excessive Thirst () Unusual Weight Change

Heme: () Enlarged Lymph Nodes () Abnormal Bleeding () Skin Discoloration () Easy Bruising
() Persistent Fever

Allergy: () Persistent Infections () Hives () Rash () Seasonal Allergies