HEALTH HISTORY QUESTIONNAIRE

Date _____

Patient Name _____ Doctor _____

Date of Birth _____ Referring Clinic _____ Acct. No _____ Chart No. _____

HISTORY OF PAST ILLNESS: Have you had

Childhood:

Measles	No	Yes
Mumps	No	Yes
Chickenpox	No	Yes
Diabetes	No	Yes
Strokes	No	Yes
Cancer	No	Yes
Rheumatic Fever	No	Yes
Heart Disease	No	Yes
Tuberculosis	No	Yes
Venereal Disease	No	Yes
Congenital Abnormalities	No	Yes
Meningitis	No	Yes
Pneumonia	No	Yes
Radiation Therapy	No	Yes
Hepatitis	No	Yes
Blood Transfusion	No	Yes
Other Serious Diseases	No	Yes

Please list _____

_____

_____

_____

Adult:

Any serious illness?	No	Yes
Hospitalized?	No	Yes
Under medical care for long period?	No	Yes

If yes to the above questions, please describe:

_____

_____

_____

Operations

Please list any surgeries you have had:

_____

_____

_____

Injuries

Any broken bones?	No	Yes
Any head injuries, concussions	No	Yes
Ever been knocked unconsious?	No	Yes

FAMILY HISTORY	If living Age	If living Health	If deceased Age (at death) & Cause		Has any blood relative ever had:		
Father					Cancer	No	Yes
Mother					Tuberculosis	No	Yes
Brother / Sister					Diabetes	No	Yes
					Heart Trouble	No	Yes
					High Blood Pressure	No	Yes
Husband / Wife					Stroke	No	Yes
Son / Daughter					Convulsions	No	Yes
					Suicide	No	Yes
					Insanity	No	Yes
					Bleeding Tendency	No	Yes
					Gout / Arthritis	No	Yes

Social History:

Marital Status: S M Sep D W

Are you living with your spouse?	No	Yes
Sex life satisfactory?	No	Yes
Dependents living at home?	No	Yes

Highest grade completed in school _____

How many days lost from sickness in:

Six months? ____ One year ____ Five years ____

Regular Exercise Yes ____ No ____

Alcohol Consumption Never ____ Quit ___ No. per week ____

Tobacco Never ____ Quit ___ Packs per day ___

Employment Full-time ____ Part-time ____

Job Responsibilities _____

Exposed to fumes, dust, solvents? _____

SYSTEMIC REVIEW: Do you have any of the following?

General

Recent weight change?	No	Yes
Been in good health?	No	Yes

Skin

Jaundice	No	Yes
Hives, eczema, rash	No	Yes
Frequent infection or boils	No	Yes
Abnormal pigmentation	No	Yes

Head / Eyes / Nose / Throat

Eye disease or injury	No	Yes
Do you wear glasses?	No	Yes
Double Vision	No	Yes
Headaches	No	Yes
Glaucoma	No	Yes
Itching eyes or nose	No	Yes

Head / Eyes / Nose / Throat (cont.)

Sneezing or runny nose	No	Yes
Nosebleeds	No	Yes
Chronic sinus trouble	No	Yes
Ear disease	No	Yes
Impaired hearing	No	Yes
Dizziness / blackouts	No	Yes

Neck

Stiffness	No	Yes
Thyroid trouble	No	Yes
Enlarged glands	No	Yes

Respiratory

Respiratory infections (frequent colds)	No	Yes
Spitting up blood	No	Yes
Chronic or frequent cough	No	Yes

SYSTEMIC REVIEW:

Respiratory (cont):

- Asthma or wheezing ..... No Yes
- Difficulty breathing ..... No Yes
- Lung problems of any kind ..... No Yes
- Pleurisy or pneumonia ..... No Yes

Cardiovascular

- Chest pains or angina ..... No Yes
- Shortness of breath when walking ..... No Yes
- Shortness of breath when lying down ..... No Yes
- Difficulty walking two blocks ..... No Yes
- Heart trouble or heart attacks ..... No Yes
- High blood pressure ..... No Yes
- Swelling of hands, feet, ankles ..... No Yes
- Awaking at night by "smothering" ..... No Yes
- Heart murmur ..... No Yes

Gastrointestinal

- Peptic ulcer (stomach or duodenal) ..... No Yes
- Vomiting blood or food ..... No Yes
- Gallbladdar disease ..... No Yes
- Liver trouble ..... No Yes
- Hepatitis ..... No Yes
- Painful bowel movements ..... No Yes
- Bleed with bowel movements ..... No Yes
- Black stools ..... No Yes
- Hemorrhoids or piles ..... No Yes
- Recent change in bowel habits ..... No Yes
- Frequent diarrhea ..... No Yes
- Heartburn of indigestion ..... No Yes
- Cramping or abdominal pain ..... No Yes
- Does food stick in your throat ..... No Yes

Genitourinary

- Loss of urine ..... No Yes
- Frequent urination ..... No Yes
- Night time urination ..... No Yes
- Burning or painful urination ..... No Yes
- Blood in urine ..... No Yes
- Kidney trouble ..... No Yes
- Kidney stones ..... No Yes
- Bright's Disease ..... No Yes

Gynecological

- Age periods started _____
- Length of periods _____ days
- Frequency of periods _____ days
- Date of first day of last period _
- Any pain with your periods ..... No Yes
- Number of pregnancies _____
- Number of miscarriages _____
- Number of children _____ Ages _____
- Date of last pap smear / results _____

Locomotor / Musculoskeletal

- Varicose veins ..... No Yes
- Weakness or pain of muscles or joints ..... No Yes
- Any difficulty in walking ..... No Yes
- Pain in calves, buttocks when walking ..... No Yes
- Above pain relieved with rest ..... No Yes
- Tingling of extremities ..... No Yes

Neuro / Psychaitric

- Have you ever had psychiatric care? ..... No Yes
- Ever been advised to see a psychiatrist? ..... No Yes
- Ever have, or have had, fainting spells? ..... No Yes
- Convulsions ..... No Yes
- Paralysis ..... No Yes

Hematological

- Slow to heal from cuts ..... No Yes
- Blood disease ..... No Yes
- Anemia ..... No Yes
- Phlebitis ..... No Yes
- Excessive bleeding after minor surgery ..... No Yes
- Abdominal bruising or bleeding ..... No Yes

Endocrine

- Thyroid disease ..... No Yes
- Hormone therapy ..... No Yes
- Any change in hat or glove size? ..... No Yes
- Any change in hair growth? ..... No Yes
- Do you get colder more easily? ..... No Yes
- Skin has become dryer ..... No Yes

HEIGHT _____

WEIGHT _____

ALLERGIES & SENSITIVITIES:

Do you have a history of skin or other reactions / sicknesses following the injection or oral administration of:

				Please list drug or medication
Penicillin or other antibodies	No	Yes	Not Sure	_____
Morphine / codeine / demerol / narcotics	No	Yes	Not Sure	_____
Novocaine or anesthetics	No	Yes	Not Sure	_____
Aspirin, Empirin or pain remedies	No	Yes	Not Sure	_____
Sulfa drugs	No	Yes	Not Sure	_____
Tetanus antioxin or other serums	No	Yes	Not Sure	_____
Adhesive tape	No	Yes	Not Sure	_____
Iodine or merthiolate	No	Yes	Not Sure	_____
Other drugs or medications	No	Yes	Not Sure	_____
Foods (milk, eggs, chocolate)	No	Yes	Not Sure	_____

MEDICATIONS

Drugs recently taken (within the past six months)

Sleeping pills	No	Yes	Not Sure
Recreational drugs	No	Yes	Not Sure
Cortisone	No	Yes	Not Sure
ACTH	No	Yes	Not Sure
Anticoagulants (blood thinners)	No	Yes	Not Sure
Tranquilizers	No	Yes	Not Sure
Hypotensives (high blood pressure)	No	Yes	Not Sure
Aspirin	No	Yes	Not Sure

Do you have an **Advanced Directive?**

Yes _____ No _____

Are you interested in **Advanced Directives?**

Yes _____ No _____

Source of information, if other than patient _____

Signature of person acquiring information _____

Physician Signature _____ Date _____ Patient Signature _____