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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, MI)*: ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Primary Care Physician:	
Referring Physician:	
How did you hear about us:	

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed medications and over-the-counter medications, such as vitamins and inhalers *(if more room is required, please list on back of this page)*		
Name of medication	Strength	Frequency Taken
List any allergies to medications *(if more room is required, please list on back of this page)*		
Medication Name	Reaction	

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.)				
PED	Any history of performance enhancing drug use?			☐ Yes	☐ No
Diet	Are you on a specific diet?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	How many cups per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐Yes	☐ No
	Cigarettes - ____pks/day	Chew - #____/day	Pipe - #____/day	Cigars - #____/day	
	# of years:	Year quit:			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Do you use marijuana?			☐ Yes	No
Personal Safety	Do you live alone?			Yes	No
	Do you have frequent falls?			☐ Yes	☐ No

☐
☐ ☐

	Do you have vision or hearing loss?	☐ Yes	☐No

FAMILY HEALTH HISTORY

LIVING: Y/N, AGE		SIGNIFICANT HEALTH PROBLEMS		LIVING: Y/N, AGE	SIGNIFICANT HEATLH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings				☐ M ☐ F	
☐ M ☐ F				☐ M ☐ F	
☐ M ☐ F			**Grandmother** *Maternal*		
☐ M ☐ F			**Grandfather** *Maternal*		
☐ M ☐ F			**Grandmother** *Paternal*		
			Grandfather *Paternal*		

WOMEN ONLY

Have you reached menopause		☐ Yes	☐ No
If yes, at what age?	Are you taking hormone replacement therapy?	☐ Yes	☐ No

REVIEW OF SYMPTOMS

Check if you have or have had any symptoms in the following areas to a significant degree and briefly explain. Please leave blank if you have had no symptoms.

1. General
   __ Excessive recent weight gain or loss
   __ Night sweats
   __ Fever, chills

2. Head & Neck
   __ Severe headaches
   __ Recent hoarseness
   __ Bad teeth
   __ Dentures __ Partials __ Complete

3. Respiratory
   __ Chronic cough
   __ Wheezing or Asthma
   __ Coughing up blood

4. Cardiovascular
   __ Elevated Cholesterol
   __ High blood pressure
   __ Heart Murmur
   __ Chest pain
   __ Shortness of breath (with or without exertion)
   __ Waking up at night short of breath
   __ Ankle swelling
   __ Prior leg vein stripping
   __ Pain/cramping in calves while walking
   __ History of palpitations
   __ Recurrent light headedness of dizziness
   __ Fainting or loss of consciousness

5. Gastrointestinal
   __ Frequent heartburn or indigestion
   __ Difficulty swallowing
   __ An Ulcer
   __ Black or Tarry stools
   __ Frequent nausea/vomiting

6. Hematologic
   __ Easy bruising
   __ Anemia

7. Urinary
   __ Frequent urination at night
   __ Frequent urinary tract infections
   __ Blood in urine

8. Neurologic
   __ Prior stroke
   __ Transient paralysis (or other neurologic deficit)
   __ Seizures
   __ Muscular weakness/tingling
   __ Speech difficulty
   __ Double vision/loss of vision

9. Skin
   __ Any chronic rashes or eruptions
   __ Poor healing of foot lesions or wounds
   __ Moles that are changing in size

10. Endocrine
    __ Elevated blood sugars
    __ Thyroid problems

Signature: _____ Date: _____

Thank You!