

HEALTH HISTORY QUESTIONNAIRE

Your complete, detailed responses to this questionnaire will help us to provide you with the best possible health care by learning more about you and your health history. If you have difficulty answering a question, please put a question mark (?) in that space.

Name: _____ Today's date: ___/___/___

Age: _____ Birthdate: ___/___/___ How you heard of our practice: _____

PAST HEALTH HISTORY

Please list your current health problems and how long you've had them.

Current health problem	How long present
_____	_____
_____	_____
_____	_____
_____	_____

CIRCLE IF A HEALTH CARE PROVIDER HAS TOLD YOU THAT YOU HAVE ANY OF THESE ILLNESSES

- | | | | |
|-------------------------|---------------------------|---------------------------------|---------------------|
| Anemia | Glaucoma | Arthritis or Rheumatism | Asthma |
| Gout | Stroke | Bleeding tendency | Heart trouble |
| Thyroid disease | Cancer or tumor | Hepatitis | Tuberculosis |
| Diabetes | High blood pressure | Ulcer or stomach trouble | Polio |
| Emphysema or bronchitis | Kidney or bladder trouble | Venereal disease | Seizures (epilepsy) |
| Rheumatic/scarlet fever | Mononucleosis | Depression or nervous breakdown | |

LIST ANY OTHER MAJOR ILLNESSES, OPERATIONS, HOSPITALIZATIONS, MAJOR INJURIES OR OTHER IMPORTANT HEALTH PROBLEMS YOU'VE HAD DURING YOUR LIFE

YEAR (approximate)

_____	_____
_____	_____
_____	_____

PLEASE LIST ALL ALLERGIES, INCLUDING MEDICATION, FOOD AND MEDICAL SUPPLIES, AND YOUR REACTION

ALLERGY	REACTION	ALLERGY	REACTION
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE GO TO NEXT PAGE

PLEASE LIST ALL MEDICATIONS THAT YOU TAKE, INCLUDING BIRTH CONTROL PILLS AND NON-PRESCRIPTION MEDICATIONS, SUCH AS PAINKILLERS, LAXATIVES, SLEEP AIDS, VITAMINS, ETC.

MEDICINE	FREQUENCY	MEDICINE	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is birth control one of your concerns? Y N If yes, what method do you use? _____

Have you ever had a sexually transmitted disease, such as Syphilis, Gonorrhea, Herpes, Genital Warts or Chlamydia?

Y N If yes, which one(s)? _____

Do you practice safe sex? Y N

When did you have each of the following? If never, write "never":

Complete Physical Exam _____ PAP Smear _____ EKG _____ Cholesterol Check _____

Tetanus Shot _____ Pneumonia Shot _____ Hepatitis B Series _____ TB Test _____

Mammogram _____ Bone Mineral Density _____ Colonoscopy _____ Sigmoidoscopy _____

Do you know your blood type? Y N If so, what is it? _____

SOCIAL HISTORY

Where were you born? _____ Where did you grow up? _____

Highest level of school completed _____ Current marital status _____

List the sex and ages of any children you have _____

Who, besides you, lives in your current household? _____

Are you responsible for care of an elderly adult? _____

HABITS

Do you exercise regularly? Y N If so, state details: _____

Do you smoke? Y N If yes, how many packs per day? _____ How many years? _____

If you have quit smoking, how long has it been since you've smoked? _____

Have you ever used illegal drugs? Y N If yes, which drugs? _____

Do you drink alcohol? Y N If yes, how many drinks do you have in the average week? _____

Do you drink or eat anything with caffeine? Y N If yes, how much in the average day? _____

Are you a vegetarian? Y N Do you use meditation or relaxation practices? Y N

Do you wear a seat belt in automobiles? Y N

PLEASE GO TO NEXT PAGE

Please place a check mark (v) if you've had any of the following symptoms within the last year. Leave blank if you're not sure.

HEAD/NECK

Severe headaches _____ Severe hearing loss _____ Chronic nose obstruction _____ Dizzy spells _____
Repeat nosebleeds _____ Ringing in ears _____ Double vision _____ Failing vision _____
Prolonged hoarseness _____ See 'floating lights' _____ Swelling in neck _____ Trouble swallowing _____

HEART/LUNGS

Chest pain on effort _____ Sit up to breathe easy _____ Night sweats _____ Palpitations _____
Chronic cough _____ Swollen ankles _____ Difficult breathing _____ Spit up blood _____

STOMACH/INTESTINES

Chronic abdominal pain _____ Vomiting blood _____ Blood in stool _____ Persistent nausea _____
Skin turned yellow _____ Clay colored stool _____ Heartburn _____ Chronic diarrhea _____
Chronic constipation _____ Appetite loss _____ Hemorrhoids _____ Black tarry stool _____

URINARY TRACT

Excess urination _____ Pain with urination _____ Excess night urination _____ Leakage of urine _____
Bedwetting _____ Retention of urine _____ Passed kidney stone(s) _____ Blood in urine _____

MUSCLES/JOINTS/NERVES

Tingling sensations _____ Limitation of motion _____ Numbness _____ Speech disturbance _____
Joint trouble _____ Shaking _____ Difficulty walking _____ Muscle jerking _____
Paralysis _____ Personality change _____ Varicose vein(s) _____ Memory loss _____

FAMILY HISTORY

CIRCLE IF ANY BLOOD RELATIVE HAS OR HAD THE CONDITIONS LISTED BELOW. IF THE RELATIVE IS DECEASED, INCLUDE THE AGE AT THE TIME OF DEATH

Asthma _____ High Blood Pressure _____
Cancer or tumor _____ Sickle Cell Disease _____
Diabetes _____ Glaucoma _____
Stroke _____ Tuberculosis _____
Heart Disease _____ Thyroid _____
Osteoporosis _____ Lung Disease _____
Substance Abuse _____ Mental Health _____

For Women Only

When was your last menstrual period? _____
At what age did your menstrual periods start? _____
Describe any trouble you are having with your periods (i.e. excessive bleeding, pain) _____
How many times have you been pregnant? _____
Any abortions? _____ Any miscarriages? _____ Any C Sections? _____
Do you self-examine your breasts regularly? _____
Has your mother, sister or aunt had Breast, Ovarian or Cervical (Uterine) cancer? _____
Have you been told your PAP smear was abnormal? _____

For Men Only

Do you have problems with urinating (i.e., starting, stopping problems, increased frequency, split stream)? _____
Do you have prostate problems? _____
Do you do a testicular self-exam? _____
Do you have erection problems? _____