

PERSONAL HEALTH HISTORY QUESTIONNAIRE DATE: _____ DOCTOR: _____

NAME: _____ AGE: _____ OCCUPATION: _____

CURRENT PHONE #: (H) _____ (W) _____ EMPLOYER: _____

MARITAL STATUS: Mar Sgl Div Sep Wid Date of Birth: _____

FAMILY HISTORY: If any blood relative has suffered from any of the following-please check and indicate which relative in the space provided: GP= grandparent, S= sibling, M= mother, F= father

ALL Blood Relatives including mother and father:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergy | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeds easy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Migraine | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Other Cancer | |

If mother deceased, age and cause of death: _____

If father deceased, age and cause of death: _____

HOSPITAL ADMISSIONS AND PAST ILLNESSES (including pregnancies)	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING. Include doses, herbs, and nonprescription drug.		
1.	4.	7.
2.	5.	8.
3.	6.	9.

ALLERGIES: Please list all known allergies, especially to medicines or anesthesia: _____

TESTS AND IMMUNIZATIONS : Please give the month and year of your most recent test or immunization:

- | | | | | | |
|---------|--------------|----------------|-------------------|------------|---------------|
| Eye: | Chest Xray: | Mammogram: | <u>Adult</u> ⇨ | Tetanus: | TB Skin Test: |
| Dental: | Other Xray: | PAP Smear: | | Flu: | Pneumonia: |
| EKG: | Cholesterol: | Sigmoidoscopy: | <u>Children</u> ⇨ | Hepatitis: | Other: |
| | | Colonoscopy: | | DPT: | Polio: |
| | | | | MMR: | Chicken Pox: |

HABITS:

- Smoking; #cig/day _____ X _____ Yrs Alcohol; #drinks/day _____ #/mo _____ Caffeine; #cups/day _____
- Exercise; #times/week _____ Other Drugs(i.e. chew or illegal drugs) _____

SOCIAL:

With whom do you live? _____ On whom do you depend on for transportation? _____

List all chemical, poison, toxins, dust or irritants you have been exposed to: _____

LIST DOCTORS YOU SEE CURRENTLY OR HAVE SEEN FOR MAJOR MEDICAL PROBLEMS: _____

WHAT QUESTIONS MAY I ANSWER FOR YOU CONCERNING YOUR HEALTH?

- _____
- _____
- _____

PLEASE CHECK THE ITEMS BELOW THAT YOU HAVE NOW OR HAVE HAD IN THE PAST

HEENT	Present	Past
Wear glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty hearing/seeing	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>
Blood shot eyes	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>
Ear wax problems	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus infection	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nose bleed	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums/ Sores mouth	<input type="checkbox"/>	<input type="checkbox"/>
Voice change	<input type="checkbox"/>	<input type="checkbox"/>
Radiation therapy neck/head	<input type="checkbox"/>	<input type="checkbox"/>
CV-RESP		
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Leg pain with walking/resting	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol/triglyceride	<input type="checkbox"/>	<input type="checkbox"/>
Anemia (low blood count)	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or bruising easily	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease or murmur	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Racing, pounding heart	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins/blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>
Fingers change color & hurt	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Sleep with > one pillow	<input type="checkbox"/>	<input type="checkbox"/>
Lung or breathing problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/ wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
G.I.		
Chronic abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>
Bloody or black stools	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing problem	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Polyps	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea/ Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Change in stool size/shape	<input type="checkbox"/>	<input type="checkbox"/>
GU		
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Leaking urine/ dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Urination at night	<input type="checkbox"/>	<input type="checkbox"/>
Pain or blood on urination	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder infection	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stone	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
MALES ONLY	YES	NO
Change in stream	<input type="checkbox"/>	<input type="checkbox"/>
Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>
Lumps on testicles	<input type="checkbox"/>	<input type="checkbox"/>

Difficulty with erections	<input type="checkbox"/>	<input type="checkbox"/>
NEURO-MUSCULAR	Present	Past
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Passing out/fainting	<input type="checkbox"/>	<input type="checkbox"/>
Speech problem	<input type="checkbox"/>	<input type="checkbox"/>
Weakness or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Coordination problem	<input type="checkbox"/>	<input type="checkbox"/>
Tremors or unsteadiness	<input type="checkbox"/>	<input type="checkbox"/>
Memory/thinking problem	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis or gout	<input type="checkbox"/>	<input type="checkbox"/>
Red/swollen/stiff joints	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain	<input type="checkbox"/>	<input type="checkbox"/>
Painful joints/muscle/bones	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
SKIN		
Skin disorders	<input type="checkbox"/>	<input type="checkbox"/>
Rashes/Itching	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Moles changing size/color	<input type="checkbox"/>	<input type="checkbox"/>
Dry or oily skin	<input type="checkbox"/>	<input type="checkbox"/>
METABOLIC		
Weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>
Unusual fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (high blood sugar)	<input type="checkbox"/>	<input type="checkbox"/>
Low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>
Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or anxious	<input type="checkbox"/>	<input type="checkbox"/>
Unusual loss of hair	<input type="checkbox"/>	<input type="checkbox"/>
Unusual diet	<input type="checkbox"/>	<input type="checkbox"/>
ILLNESSES		
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Drug/Alcohol addiction	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>
EMOTIONAL	YES	NO
Marital relations good	<input type="checkbox"/>	<input type="checkbox"/>
Lack of sex drive	<input type="checkbox"/>	<input type="checkbox"/>
Hobbies or recreation	<input type="checkbox"/>	<input type="checkbox"/>
Enjoy employment	<input type="checkbox"/>	<input type="checkbox"/>
Unhappy or depressed	<input type="checkbox"/>	<input type="checkbox"/>
Crying spells	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thought/intent	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
FEMALES ONLY		
Menstrual trouble	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Problem getting pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Breast lump or pain	<input type="checkbox"/>	<input type="checkbox"/>
Do you do self-breast exams	<input type="checkbox"/>	<input type="checkbox"/>
Age of first menses _____		
First day of last menses _____		
#Pregnancies _____ #Miscarriages _____		
#Abortions _____ #C-Sections _____		
Pregnancy complications	<input type="checkbox"/>	<input type="checkbox"/>
Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>

Menopause: Date last menses _____

Hormone replacement

Emotional changes

Hot flashes/ night sweats

BOTH MALES AND FEMALES

Sexually transmitted diseases

Sexual concerns

Bisexual/homosexual

Type of birth control _____

ALLERGIES:

FOR OFFICE USE ONLY
CHIEF COMPLAINT:

RECOMMENDATIONS: