

# PERSONAL HEALTH HISTORY QUESTIONNAIRE

DATE: \_\_\_\_\_ Health Care Provider: \_\_\_\_\_

<b>Patient Name:</b>	<b>Date Of Birth</b>	<b>Age:</b>
<b>Occupation:</b>	<b>Employer:</b>	
<b>With Whom Do You Live?</b>	<b>On Whom Do You Depend On For Transportation?</b>	
<b>Partner Status:</b> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner <input type="checkbox"/>		

## FAMILY HISTORY

If any blood relative has suffered from any of the following, please check and indicate which relative in the space provided:

Please List **ALL** Blood Relatives - GP= Grandparent, S= Sibling, M= Mother, F= Father

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Clotting Disorders _____ | <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Stroke _____           |
| <input type="checkbox"/> Allergy _____    | <input type="checkbox"/> Diabetes _____           | <input type="checkbox"/> Hypertension _____     | <input type="checkbox"/> Stomach Problems _____ |
| <input type="checkbox"/> Anemia _____     | <input type="checkbox"/> Dementia _____           | <input type="checkbox"/> Mental Illness _____   | <input type="checkbox"/> Tuberculosis _____     |
| <input type="checkbox"/> Arthritis _____  | <input type="checkbox"/> Glaucoma _____           | <input type="checkbox"/> Migraine _____         | <input type="checkbox"/> Breast Cancer _____    |
| <input type="checkbox"/> Asthma _____     | <input type="checkbox"/> Heart Disease _____      | <input type="checkbox"/> Osteoporosis _____     | <input type="checkbox"/> Colon Cancer _____     |
|   |   | <input type="checkbox"/> Seizures _____         | <input type="checkbox"/> Other Cancer _____     |

If Mother Deceased, Age & Cause of Death: \_\_\_\_\_

If Father Deceased, Age & Cause of Death: \_\_\_\_\_

HOSPITAL ADMISSIONS	YEAR	ILLNESS/OPERATION	YEAR	ILLNESS/OPERATION
(Please Include Pregnancies & Past Illnesses)				

## List Name & Dosage of All Medications That You Are Taking

Please Include: Prescriptions, Supplements, & Non-Prescription Drugs

1.	4.	7.
2.	5.	8.
3.	6.	9.

## ALLERGIES

Please List All Known Allergies, Especially to Medicines or Anesthesia:

## Please List The Month & Year Of Your Most Recent: Tests, Exams and Immunizations

Eye Exam:	Stool Card:	Pneumonia Vaccine (65 yrs. and older):
Diabetic Foot Exam:	PAP Smear:	Shingles Vaccine (60 yrs. and older):
Dental Exam:	Cholesterol Screen:	Hepatitis Vaccine:
Mammogram:	Other Labs:	HPV:
Colonoscopy:	Tetanus Shot (every 10 years):	TB Skin Test:
Sigmoidoscopy:	Flu Shot:	

## List Health Care Providers

That You See Currently (Or Have Seen) For Your Major Medical Problems


## Habits

- Smoking; #Cig/Day      For      Yrs.       Alcohol; #Drinks/Day      #Drinks/Mo.       Caffeine; #Cups/Day
- Exercise; #Times/Week       Other Drugs (I.E. Chew Or Illegal Drugs)

## 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**

Wear Glasses/Contacts	Present <input type="checkbox"/>	Past <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"/>
Hay Fever	<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	Present <input type="checkbox"/>	Past <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"/>
Difficulty Laying Flat	<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"/>

**GI**

Chronic Abdominal Pain	Present <input type="checkbox"/>	Past <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	Present <input type="checkbox"/>	Past <input type="checkbox"/>
Leaking Urine/ Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Urination at Night > 1 Time	<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**

Change in Stream	YES <input type="checkbox"/>	NO <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**

Headaches	Present <input type="checkbox"/>	Past <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	Present <input type="checkbox"/>	Past <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	Present <input type="checkbox"/>	Past <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"/>

**FEMALES ONLY**

Age of First Menses	YES	NO
First Day of Last Menses	_____	_____
Menstrual Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty 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"/>
#Pregnancies _____	#Miscarriages _____	
#Abortions _____	#C-Sections _____	
Pregnancy Complications	<input type="checkbox"/>	<input type="checkbox"/>
Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Changes	<input type="checkbox"/>	<input type="checkbox"/>
<b>MENOPAUSE</b>	YES	NO
Hormone Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes/ Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>

**BOTH MALES AND FEMALES**

Sexually Transmitted Diseases	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Sexual Concerns	<input type="checkbox"/>	<input type="checkbox"/>
Partner Preference	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Male	<input type="checkbox"/> Female
	<input type="checkbox"/> Both	
Type of Birth Control Used (If Needed/Desired)	_____	

**ILLNESSES**

Polio	Present <input type="checkbox"/>	Past <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**

Partner Relations Good	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Lack of Sex Drive	<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"/>

**Thank You For Your Time!**

