PATIENT NAME: _____

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HEALTH HISTORY QUESTIONNAIRE

A. HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING:

___ AMPUTATION
___ANEMIA
___ARTHRITIS
___ARTHRITIS, RHEUMATOID
___ASTHMA
___BACK PROBLEMS
___BLEEDING DISEASE
___BRONCHITIS
___CANCER
___CHRONIC COUGH
___CONSTIPATION
___COPD
___DEPRESSION
___DIABETES
___DIARRHEA
___DIZZINESS
___EMPHYSEMA
___EYESIGHT PROBLEMS
___FAINTING-SYNCOPE
___FRACTURES/BROKEN BONES
___GALLBLADDER DISEASE
___GOUT
___HEADY INJURY
___HEADACHES
___HEARING LOSS
___HEART DISEASE
___HEPATITIS
___HERNIA
___HIGH BLOOD PRESSURE
___HIGH CHOLESTEROL
___HIV INFECTION
___HYPERLIPIDEMIA
___KIDNEY CONDITION-RENAL
___LIVER, STOMACH, OR BOWEL DISEASE
___MENTAL DISABILITY
___METABOLIC SYNDROME
___NONMOVING LIMBS-PARALYSIS
___NUMBNESS-HYPESTHESIA
___OSTEOPOROSIS
___PNEUMONIA
___SCOLIOSIS
___SEIZURE DISORDER-EPILEPSY
___SHORT OF BREATH-DYSPNEA
___SINUS PROBLEMS
___SKIN DISORDERS
___SPINE DISORDERS
___STROKE SYNDROME
___SWELLING OF FEET OR LEGS
___THYROID DISEASE
___TUBERCULOSIS
___ULCER DISEASE
___URINARY TRACT INFECTION
___VARICOSE VEINS
___VENEREAL DISEASE-STD
___WEIGHT GAIN (RECENT)
___WEIGHT LOSS (RECENT)
___ _____
___ _____
___ _____
___ _____
___ _____
___ _____

B. WHAT DOCTOR'S ARE CURRENTLY OR HAVE PREVIOUSLY TREATED YOU?

_____

_____

C. SOCIAL HISTORY

1. DO YOU PRESENTLY **DRINK ALCOHOL**? **YES OR NO.**
WHAT TYPE? **___BEER ___WINE ___LIQUOR**
HOW MUCH DO YOU DRINK PER DAY? **_____**
HAVE YOU **PREVIOUSLY** DRANK **ALCOHOL** ON A DAILY BASIS? **YES OR NO.** WHAT YEAR DID YOU QUIT**? _____**
2. DO YOU DRINK CAFFEINE? **___COFFEE ___TEA ___SODAS**
3. HOW MANY **CHILDREN** DO YOU HAVE? ___
4. DO YOU USE **ILLEGAL/STREET DRUGS**? **YES OR NO.**
HAVE YOU PREVIOUSLY USED ILLEGAL/STREET DRUGS? YES OR NO. WHAT YEAR DID YOU QUIT? _____
5. WHAT IS YOUR MARITAL STATUS? **___MARRIED ___SINGLE ___SEPARATED ___DIVORCED ___WIDOWED**
6. HOW MANY YEARS OF **SCHOOL** HAVE YOU COMPLETED? **_____**
7. HAVE YOU EVER **SMOKED? YES OR NO.** HOW MANY PACKS PER DAY**: _____** FOR HOW MANY YEARS**: _____**
IF YOU HAVE SMOKED IN THE PAST WHAT YEAR DID YOU QUIT**? _____** PACKS PER DAY**: _____** HOW MANY YEARS**: _____**
DOES YOUR **SPOUSE** SMOKE? **YES OR NO.**
8. DO YOU USE **SNUFF OR CHEWING** TOBACCO? **YES OR NO.**
IF YOU HAVE USED THESE PRODUCTS IN THE PAST, WHAT YEAR DID YOU QUIT**? _____**
9. DO YOU HAVE A **LIVING WILL**? **YES OR NO.**

PATIENT NAME: _____

D. SURGICAL HISTORY

PLEASE LIST ANY **SURGICAL PROCEDURES** YOU HAVE HAD IN THE PAST: (TYPE OF PROCEDURE AND DATE)

1. _____
2. _____
3. _____
4. _____
5. _____

E. HEALTH MAINTENANCE INFORMATION

LIST THE DATE OF YOUR LAST TEST:

PAP SMEAR: _____ **MAMMOGRAM: _____**

HEMOCCULT: _____ **SIGMOID: _____**

DEXA SCAN: _____ **PSA: _____**

EYE EXAM: _____

F. FAMILY HISTORY

HAS A MEMBER OF YOUR FAMILY HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

PLEASE PLACE A CHECK BELOW THE FAMILY MEMBER AND ACROSS FROM THE DISEASE.

	MOM	DAD	BROTHER	SISTER	SON	DAUGHTER	MGM	PGM	MGF	PGF	OTHER
ALCOHOLISM											
ASTHMA											
AUTOIMMUNE DISEASE											
DIABETES											
HEART DISEASE											
HYPERTENSION											
KIDNEY DISEASE											
MENTAL DISABILITY											
MIGRAINE HEADACHE											
SEIZURE DISORDER											
STROKE SYNDROME											
TUBERCULOSIS											
CANCER (IF CANCER, PLEASE LIST WHAT TYPE)											

☐ PLEASE CHECK HERE IF YOUR **FAMILY HISTORY** IS **UNKNOWN**

E. MEDICATIONS AND ALLERGIES

MEDICATIONS: 1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

9. _____ 10. _____

ALLERGY	**REACTION**	**ALLERGY**	**REACTION**
_____		_____	
_____		_____	
_____		_____	

THANK YOU FOR FILLING OUT THIS FORM. YOUR COOPERATION WILL MAKE IT MUCH EASIER FOR YOUR DOCTOR TO HELP YOU.

SIGNATURE: _____ DATE: _____