

Health History Questionnaire

Patient Name: _____

Date of Birth: _____ Today's Date: _____

Reason for Appointment: _____

Previous Family Doctor: _____ Date Last Seen: _____

Medical History

Circle Yes or No

Allergies: _____

Diabetes	Yes	No
High Blood Pressure	Yes	No
Cancer	Yes	No
Stroke	Yes	No
Heart Trouble	Yes	No
Arthritis/Gout	Yes	No
Bleeding Problems	Yes	No
Glaucoma	Yes	No
Stomach Ulcers	Yes	No
Thyroid Trouble	Yes	No
Venereal Disease	Yes	No

Female Patients: Menstrual History
 Age at Onset _____ Cycle Length (days) _____
 # of Pregnancies _____ Live Births _____
 Miscarriages _____ Abortions _____
 Age at Menopause _____
 Date last Menstrual Period Began _____
 Last Pap Smear _____ Last Mammo _____

Family Medical History (Living or Deceased)

	Age	Diseases	Cause of death if known
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Past Medical History:

Previous Hospitalizations/Surgeries (Type of Surgery, Hospital Date):

Medications – Please bring all bottles of current medication with you.

Social History:

Use of Alcohol: Never _____ Rarely _____ Moderate _____ Daily _____
 Use of Tobacco: Never _____ Current Packs/Day _____ Year Started _____ Year Quit _____
 Use of Illegal Drugs: Never _____ Type/Frequency _____
 Employed _____ Retired _____ What kind of work _____
 Hobbies/Interest _____

Other information you think might be helpful for us to provide you with the best medical care.

Please continue on back!

Review of Systems: Are you currently experiencing any of the following? Please answer all questions

CONSTITUTIONAL

Activity change No Yes
 Appetite change No Yes
 Chills No Yes
 Diaphoresis (excessive sweating) No Yes
 Fatigue No Yes
 Fever No Yes
 Recent weight change No Yes

HENT

Neck pain No Yes
 Neck stiffness No Yes
 Ear discharge/drainage No Yes
 Hearing loss No Yes
 Ear pain No Yes
 Tinnitus (ringing in the ears) No Yes
 Nose bleeds No Yes
 Congestion No Yes
 Rhinorrhea (runny nose) No Yes
 Post nasal drip No Yes
 Sneezing No Yes
 Sinus pressure No Yes
 Dental problems No Yes
 Mouth sores No Yes
 Sore throat No Yes
 Trouble swallowing No Yes
 Voice change No Yes

EYES

Eye discharge No Yes
 Eye itching No Yes
 Eye pain No Yes
 Eye redness No Yes
 Photophobia (abnormal sensitivity to light) No Yes
 Visual disturbance No Yes

RESPIRATORY

Apnea (pauses in breathing) No Yes
 Chest tightness No Yes
 Choking No Yes
 Coughing No Yes
 Shortness of breath No Yes
 Stridor (high-pitched breathing sound) No Yes
 Wheezing No Yes

CARDIOVASCULAR

Chest pains No Yes
 Leg swelling No Yes
 Palpitations (sudden heart beat changes) No Yes

GASTROINTESTINAL

Abdominal distention No Yes
 Abdominal pain No Yes
 Anal bleeding No Yes
 Blood in stool No Yes
 Constipation No Yes
 Diarrhea No Yes
 Nausea No Yes
 Rectal pain No Yes
 Vomiting No Yes

ENDOCRINE

Cold intolerance No Yes
 Heat intolerance No Yes
 Polydipsia (excessive thirst) No Yes
 Polyphagia (excessive hunger) No Yes
 Polyuria (excessive urination) No Yes

GENITOURINARY

Difficulty urinating No Yes
 Dysuria (painful urination) No Yes
 Enuresis (night-time incontinence) No Yes
 Flank pain No Yes
 Frequent urination No Yes
 Genital sore No Yes
 Hematuria (blood in urine) No Yes
 Male - Penile discharge No Yes
 Male - Penile pain No Yes
 Male - Penile swelling No Yes
 Male - Scrotal swelling No Yes
 Male - Testicular pain No Yes
 Urgency No Yes
 Urine decreased No Yes
 Change of force of strain when urinating No Yes
 Incontinence or dribbling No Yes
 Sexual difficulty No Yes
 Female – pain with periods No Yes
 Female – irregular periods No Yes
 Female – vaginal discharge No Yes

MUSCULOSKELETAL

Arthralgias (joint pain) No Yes
 Back pain No Yes
 Gait problems No Yes
 Joint swelling No Yes
 Myalgias (muscle pain) No Yes

SKIN

Change in skin color No Yes
 Pallor (pale color of the skin) No Yes
 Rash No Yes
 Wound No Yes

ALLERGIC/IMMUNOLOGIC

Environmental allergies No Yes
 Food allergies No Yes
 Immunocompromised No Yes

NEUROLOGICAL

Dizziness No Yes
 Facial asymmetry No Yes
 Headaches No Yes
 Light headedness No Yes
 Numbness or tingling sensations No Yes
 Convulsions or seizures No Yes
 Speech difficulty No Yes
 Syncope No Yes
 Tremors No Yes
 Weakness No Yes

HEMATOLOGIC/LYMPATIC

Adenopathy (abnormal lymph nodes) No Yes
 Easily bruise or bleed No Yes

PSYCHIATRIC

Agitation No Yes
 Behavioral problems No Yes
 Confusion No Yes
 Decreased Concentration No Yes
 Dysphoric mood (Depression) No Yes
 Hallucinations No Yes
 Hyperactive No Yes
 Self-injury No Yes
 Sleep disturbance No Yes
 Suicidal ideas No Yes
 Anxiety No Yes