# HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Age: _____ Sex: _____ DOB: _____

Family Doctor: _____ Office Telephone #: _____

Doctor's Address: _____
Street City State Zip

Are you currently under the care of any other physician? _____YES _____NO
*If yes, please list the physician's name and what you are being treated for:*

Name: _____ Treated for: _____
Name: _____ Treated for: _____
Name: _____ Treated for: _____

Are you pregnant? _____YES _____NO Date of last menstrual period? _____

HOSPITALIZATIONS AND OPERATIONS:
*(Please list any operations and admissions to the hospital)*

Hospital Facility: _____ Admitted for: _____
Hospital Facility: _____ Admitted for: _____
Hospital Facility: _____ Admitted for: _____
Hospital Facility: _____ Admitted for: _____

# PATIENT & FAMILY HEALTH HISTORY

*Please check if anyone in your family has had problems with the following:*

| | Patient | Father/Mother | Sister/Brother | Children |
|---|---|---|---|---|
| Heart Disease | ☐ | ☐ | ☐ | ☐ |
| Blood Pressure | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ | ☐ |
| Bleeding Problems | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ |
| Anesthesia | ☐ | ☐ | ☐ | ☐ |

Do you smoke? _____YES _____ NO
*If yes, how many packs per day?* _____ *for how long?* _____

Have you smoked in the past? _____YES _____ NO
*If yes, for how long did you smoke?* _____

Do you drink alcohol? _____YES _____ NO
*If yes, how many drinks do you have in a week?* _____

Do you take addicting drugs? _____YES _____NO
*If yes, what are they?* _____

Is there anything else about yourself that the doctor should know? _____

_____

# SYSTEMS REVIEW

*General*
Weight Gain/Loss □ Yes □ No
Fevers/Chills □ Yes □ No
Night Sweats □ Yes □ No

*Gastrointestinal*
Loss of Appetite □ Yes □ No
Nausea/Vomiting □ Yes □ No
Diarrhea □ Yes □ No
Constipation □ Yes □ No
Change in Bowel Habits □ Yes □ No
Abdominal Pain □ Yes □ No
Heartburn/Reflux □ Yes □ No
Dark Bloody Stools □ Yes □ No

*Neurological*
Headaches □ Yes □ No
Seizures □ Yes □ No
Tremor □ Yes □ No
Confusion □ Yes □ No
Memory Loss □ Yes □ No

*ENT*
Neck Masses □ Yes □ No
Ear Pain □ Yes □ No
Hoarseness □ Yes □ No

*Psychological*
Anxiety □ Yes □ No
Depression □ Yes □ No
Stress □ Yes □ No
Suicidal Thoughts □ Yes □ No

*Cardiovascular*
Chest Pain □ Yes □ No
History of MI □ Yes □ No
Palpitations □ Yes □ No
Shortness of Breath □ Yes □ No
Swelling of Feet/Legs □ Yes □ No

*Kidneys/Bladder*
Painful Urination □ Yes □ No
Frequent Urination □ Yes □ No
Incontinence □ Yes □ No
Bloody Urine □ Yes □ No

*Endocrine*
Excessive Thirst □ Yes □ No
Heat/Cold Intolerance □ Yes □ No
Hair Loss □ Yes □ No
Change in Hair Texture □ Yes □ No
Decreased Energy □ Yes □ No

*Hematological*
Easy Bruising □ Yes □ No
Swollen Lymph Nodes □ Yes □ No
Excessive Bleeding □ Yes □ No

*Respiratory*
Persistent Cough □ Yes □ No
Shortness of Breath □ Yes □ No
Bloody Sputum □ Yes □ No
History of Pneumonia □ Yes □ No
Sleep Apnea □ Yes □ No

Other Symptoms *(please describe)*: _____

_____

Patient Signature: _____ Date: _____

Medical Assistant Signature: _____ Date: _____