HEALTH HISTORY QUESTIONNAIRE

Today's Date: ______________

Name *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		**Occupation:** ____________________________
Previous doctor (for New Patients)		**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Tetanus ☐ TDAP	☐ Pneumonia- Prevnar 13
	☐ Hepatitis	☐ Pneumonia- Pneumovax 23
	☐ Influenza	☐ Shingles- Zostavax

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason/Surgery	Doctor

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of medication	Strength	Directions

Allergies to medications

Name of Medication	Reaction You Had

Social History

Tobacco use: Yes_____ No/Never_______ If yes: Years used_____ Age quit_____ Smoke exposure: yes_____ No_____ If yes, where?____________________________________	Any Illicit drug use: Yes_____ No______ Alcohol use: Yes_____ No_____ If yes, how much?___________________ Do you have children? Boys________Girls_________ ☐ No children

Patient Name: Patient Date of Birth:

Family History		☐ Adopted – no family history	
Relationship to patient:	Illness (Cancer, Diabetes, Stroke, Heart Attack, High Blood Pressure, High Cholesterol etc.)	Age of onset	Age at Death
Father			
Mother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibling			
Sibling			
Other			

Diagnostic History	
Type of diagnostic test:	Date and ordering Doctor
Colonoscopy	
Bone Density	
Stress test	
Mammogram	
Pap Smear	
Other:	

Review of Systems -Check the box for symptoms you have or problems recurring in the last 6 months.

CONSTITUTIONAL:

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss

HEENT:

- ☐ Ear drainage
- ☐ Ear pain
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Nasal drainage
- ☐ Sinus pressure
- ☐ Sore throat
- ☐ Visual changes

RESPIRATORY:

- ☐ Chronic cough
- ☐ Cough
- ☐ Known TB exposure
- ☐ Shortness of breath
- ☐ Wheezing

CARDIOVASCULAR:

- ☐ Chest pain
- ☐ Claudication
- ☐ Edema
- ☐ Palpitations

Other:

GASTROINTESTINAL:

- Abdominal pain
- Blood in stools
- Change in stools
- Constipation
- Diarrhea
- Heartburn
- Loss of appetite
- Nausea
- Vomiting

GENITOURINARY:

- Painful urination
- Blood in urine
- Increased urination
- Urinary frequency
- Urinary incontinence
- Urinary retention

REPRODUCTIVE MALE:

- Erectile dysfunction
- Penile discharge
- Sexual dysfunction

REPRODUCTIVE FEMALE:

- Abnormal pap
- Painful periods
- Pain with intercourse
- Hot flashes
- Irregular menses
- Vaginal discharge

NEUROLOGICAL:

- Dizziness
- Extremity numbness
- Extremity weakness
- Gait disturbance
- Headache
- Memory loss
- Seizures
- Tremors

INTEGUMENTARY:

- Breast discharge
- Breast lump
- Brittle hair
- Brittle nails
- Hair changes
- Abnormal facial hair
- Hives
- Itching
- Mole changes
- Rash
- Skin lesion

METOBOLIC/ENDOCRINE:

- Cold intolerance
- Heat intolerance
- Increased thirst
- Increased hunger

PSYCHIATRIC:

- Anxiety
- Depression
- Insomnia

MUSKULOSKELETAL:

- Back pain
- Joint pain
- Joint swelling
- Muscle weakness
- Neck pain

HEMATOLOGIC/LYMPHATIC

- Easy bleeding
- Easy bruising
- Swollen lymph nodes

IMMUNOLOGIC:

- Contact allergy
- Environmental Allergies
- Food allergies
- Seasonal allergies