

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?* _____

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: _____