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Original Date:

Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other:			
Previous or referring doctor:		Date of last physical exam:	
PERSONAL HEALTH HISTORY			
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia	
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox	
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>	
List any medical problems that other doctors have diagnosed			
Surgeries			
Year	Reason	Hospital	
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers			
Name the Drug	Strength	Frequency Taken	
Allergies to medications			
Name the Drug	Reaction You Had		

HEALTH HABITS AND PERSONAL SAFETY		

Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day:	<input type="checkbox"/> # of years:	<input type="checkbox"/> Or year quit:
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?		

FAMILY HEALTH HISTORY		
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	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		
Sibling	<input type="checkbox"/> M	
	<input type="checkbox"/> F	
	<input type="checkbox"/> M	
	<input type="checkbox"/> F	
	<input type="checkbox"/> M	
	<input type="checkbox"/> F	
	<input type="checkbox"/> M	
	<input type="checkbox"/> F	

WOMEN ONLY		
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Age at onset of menstruation:		Date of last menstruation:		Period every		days
Number of pregnancies		Number of live births				
Heavy periods, irregularity, spotting, pain, or discharge?						
Any urinary tract, bladder, or kidney infections within the last year?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?						

MEN ONLY		
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Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times		
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Date of last prostate and rectal exam?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
OTHER PROBLEMS			
Check if you have or had any symptoms in the following areas to a significant degree and briefly explain.			
<input type="checkbox"/> Skin:	<input type="checkbox"/> Chest/Heart:	<input type="checkbox"/> Recent changes in:	
<input type="checkbox"/> Head/Neck:	<input type="checkbox"/> Back:	<input type="checkbox"/> Weight:	
<input type="checkbox"/> Ears:	<input type="checkbox"/> Intestinal:	<input type="checkbox"/> Energy level:	
<input type="checkbox"/> Nose:	<input type="checkbox"/> Bladder:	<input type="checkbox"/> Ability to sleep:	
<input type="checkbox"/> Throat:	<input type="checkbox"/> Bowel:	<input type="checkbox"/> Other pain/discomfort:	
<input type="checkbox"/> Lungs:	<input type="checkbox"/> Circulation:		