HEALTH HISTORY QUESTIONNAIRE

Patient Name: Doctor:

Date of Birth: Referring Clinic: ______________________ Chart No.:

HISTORY OF PAST ILLNESS: Have you had

Childhood:

Measles	No	Yes
Mumps	No	Yes
Chickenpox	No	Yes
Diabetes	No	Yes
Strokes	No	Yes
Cancer	No	Yes
Rheumatic Fever	No	Yes
Heart Disease	No	Yes
Tuberculosis Venereal Disease	No	Yes
Congenital Abnormalities	No	Yes
Other Serious Diseases	No	Yes
Please list	No	Yes

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Adult

Any serious illnesses?	No	Yes
Hospitalized?	No	Yes
Under medical care for long period?	No	Yes

If yes to the above questions, please describe:

____

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Operations

Please list any surgeries you have had:

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____

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Injuries

Any broken bones?	No	Yes
Any head injuries, concussions?	No	Yes
Even been knocked unconscious?	No	Yes

Family History	If living		If Deceased	
	Age	Health	Age (at death) & Cause	
Father				
Mother				
Brother				
Husband/Wife				
Son/daughter				

Has any relative ever had:		
Cancer	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
Heart Trouble	No	Yes
High Blood Pressure	No	Yes
Stroke	No	Yes
Convulsions	No	Yes
Suicide	No	Yes
Insanity	No	Yes
Bleeding Tendency	No	Yes
Gout/Arthritis	No	Yes

Social History

Marital Status S M Sep D W

Are you living with your spouse?	No	Yes
Sex life satisfactory?	No	Yes
Dependents living at home?	No	Yes

Highest grade completed in school______________

Alcohol Consumption Never ________Quit______No. per week _____

Tobacco Never ______Quit_______Packs per day ______

Employment Full-time _____Part-time________

Job Responsibilities ______________________

Exposed to fumes, dust, solvents? ______________________

How many days lost from sickness in Six months?______________ One Year?______________Five Years?____________

SYSTEMIC REVIEW: Do you have any of the following?

General

Recent weight change?	No	Yes
Been in good health?	No	Yes

Skin

Jaundice	No	Yes
Hives, exzema, rash	No	Yes
Frequent infection or boils	No	Yes
Abnormal pigmentation	No	Yes

Head/Eyes/Nose/Throat

Eye disease or injury?	No	Yes
Do you wear glasses?	No	Yes
Double vision	No	Yes
Headaches	No	Yes
Glaucoma	No	Yes
Itching eyes or nose	No	Yes

Head/Eyes/Nose/Throat

Sneezing or runny nose	No	Yes
Nosebleeds	No	Yes
Chronic sinus trouble	No	Yes
Ear disease	No	Yes
Impaired hearing	No	Yes
Dizziness/blackouts	No	Yes

Neck

Stiffness	No	Yes
Thyroid trouble	No	Yes
Enlarged glands	No	Yes

Respiratory

Respiratory infections (frequent colds)	No	Yes
Spitting up blood	No	Yes
Chronic or frequent cough	No	Yes

SYSTEMIC REVIEW:

Respiratory (coni)

Asthma or wheezing	No	Yes
Difficulty breathing	No	Yes
Lung problems of any kind	No	Yes
Pleurisy or pneumonia	No	Yes

Cardiovascular

Chest pains or angina	No	Yes
Shortness of breath with walking	No	Yes
Shortness of breath when lying	No	Yes
Difficulty walking two blocks	No	Yes
Heart trouble or heart attacks	No	Yes
High blood pressure	No	Yes
Swelling of hands,feet,ankles	No	Yes
Awaking at night by "smothering"	No	Yes
Heart murmur	No	Yes

Gastrointestinal

Peptic ulcer (stomach or duodenal)	No	Yes
Vomiting blood or food	No	Yes
Gallbladder disease	No	Yes
Liver trouble	No	Yes
Hepatitis	No	Yes
Painful bowel movements	No	Yes
Bleed with bowel movements	No	Yes
Black stools	No	Yes
Hemorrhoids or piles	No	Yes
Recent change in bowel habits	No	Yes
Frequent diarrhea	No	Yes
Heartburn or indigestion	No	Yes
Cramping or abdominal pain	No	Yes
Does food stick in your throat	No	Yes

Genitourinary

Loss of urine	No	Yes
Frequent urination	No	Yes
Nigh time urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Kidney trouble	No	Yes
Kidney stones	No	Yes
Bright's Disease	No	Yes

Gynecological

Age periods started ______

Length of periods ______ days

Frequency of periods, every ______days

Date of first day of last period ______

Any pain with your periods No Yes

Number of pregnancies ______

Number of miscarriages ______

Number of children ______ Ages______

Date of last pap smear/results______

Locomotor/Musculoskeletal

Varicose veins	No	Yes
Weakness or pain of muscles or joints	No	Yes
Any difficulty in walking	No	Yes
Pain in calves,buttocks when walking	No	Yes
Above pain relieved with rest	No	Yes
Tingling of extremities	No	Yes

Neuro/Psychiatric

Have you ever had psychiatric care?	No	Yes
Even been advised to see a psychiatrist	No	Yes
Ever have, or have had, fainting spells	No	Yes
Convulsions	No	Yes
Paralysis	No	Yes

Hematological

Slow to heal from cuts	No	Yes
Blood disease	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Excessive bleeding after minor surgery	No	Yes
Abdominal bruising or bleeding	No	Yes

Endocrine

Thyroid disease	No	Yes
Hormone therapy	No	Yes
Any change in hat or glove size	No	Yes
Any change in hair growth	No	Yes
Do you get colder more easily?	No	Yes
Skin has become dryer	No	Yes

HEIGHT ______

WEIGHT______

Allergies and Sensitivities

1. Do you have a history of skin or other reactions/sicknesses following the injection or oral administration of?

				Please list drug or medication
Penicillin or other antibiotics	No	Yes	Not Sure	
Morphine/codeine/Demerol/narcotics	No	Yes	Not Sure	
Novocaine or anesthetics	No	Yes	Not Sure	______
Aspirin, Empirin or pain remedies	No	Yes	Not Sure	______
Sulfa drugs	No	Yes	Not Sure	______
Tetanus antitoxin or other serums	No	Yes	Not Sure	______
Adhesive tape	No	Yes	Not Sure	______
Iodine or merthiolate	No	Yes	Not Sure	______
Other drugs or medications	No	Yes	Not Sure	______
Foods (milk, eggs, chocolate)	No	Yes	Not Sure	______

2. Drugs recently taken (within the past six months)

Cortisone	No	Yes	Not Sure
ACTH	No	Yes	Not Sure
Anticoagulants (blood thinners)	No	Yes	Not Sure
Tranquilizers	No	Yes	Not Sure
Hypotensives (high blood pressure)	No	Yes	Not Sure
Aspirin	No	Yes	Not Sure

Source of information, if other than patient______

Signature of person acquiring information ______

Doctor ______ Date ______ Patient Signature______