

HEALTH HISTORY QUESTIONNAIRE

All answers 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"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
DOCTORS Names and Locations		DATE OF LAST VISIT	
Primary care doctor			
Cardiac/Heart doctor:			
Pulmonary/Lung doctor:			
Ophthalmology/Eye doctor:		Last dilated eye exam	
Podiatrist/Foot doctor:			
Other doctors you see:			

PERSONAL HEALTH HISTORY

Why are you being referred?

List all medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Tobacco	Do you use tobacco?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – packs/day	<input type="checkbox"/> Chew #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/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
	Have you ever given yourself street drugs with a needle?				<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
Mother				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Maternal</i>		
<input type="checkbox"/> M		Grandfather			
<input type="checkbox"/> F		<i>Maternal</i>			
<input type="checkbox"/> M		Grandmother			
<input type="checkbox"/> F		<i>Paternal</i>			
<input type="checkbox"/> M		Grandfather			
<input type="checkbox"/> F		<i>Paternal</i>			

OTHER PROBLEMS

Check if you have, or have 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	

VACCINATIONS

Date of last flu vaccine _____ Date of last pneumonia vaccine _____ Date of last Hepatitis B vaccine _____