

Permission for Other Person(s) to Discuss Results/Medical Condition/Etc. <input type="checkbox"/> Yes <input type="checkbox"/> No			B/P:	Resp:
If Yes, list contact person & phone:			Heart Rate:	Temp:
Name:	Relationship:	Phone:	O2:	Weight:
Name:	Relationship:	Phone:	Pharmacy:	

HEALTH HISTORY QUESTIONNAIRE

Patient Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
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HISTORY OF PRESENT ILLNESS

Primary Care Physician:	Chief Complaint:
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Explain why we are seeing you today:	
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PAST MEDICAL HISTORY (List any medical problems that other doctors have diagnosed)

PAST SURGICAL HISTORY (List any past Surgeries you have had)

Year	Reason	

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

Name the Drug	Strength	Frequency Taken

ALLERGIES

Name the Drug	Reaction You Had	Latex Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No
		Anesthesia Complications <input type="checkbox"/> Yes <input type="checkbox"/> No
		Bleeding Complications <input type="checkbox"/> Yes <input type="checkbox"/> No

SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

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
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Employment:	<input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed
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Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely
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Tobacco	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes ____ pks/day <input type="checkbox"/> Cigars ____#/day <input type="checkbox"/> Chew ____#/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
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**FAMILY HEALTH HISTORY
(IMMEDIATE FAMILY MEMBERS: MOTHER/FATHER/SIBLINGS)**

LIST SIGNIFICANT HEALTH PROBLEMS
(DIABETES, HIGH BLOOD PRESSURE, CANCER, ETC)

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(DIABETES, HIGH BLOOD PRESSURE, CANCER, ETC)

Relationship	Health Condition	Relationship	Health Condition

REVIEW OF SYSTEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

GENERAL SYMPTOMS	HEART	RESPIRATORY
<input type="checkbox"/> Fever	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Chills	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Persistent Cough
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Shortness of Breath
VISION / EYES	<input type="checkbox"/> Passing Out	<input type="checkbox"/> Wind Easily
<input type="checkbox"/> Blurring	SKIN	BLOOD / LYMPH
<input type="checkbox"/> Doubling	<input type="checkbox"/> Rash	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Blindness	<input type="checkbox"/> Boils	<input type="checkbox"/> Bleeding
ALLERGY / IMMUNE	<input type="checkbox"/> Itching	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Hayfever	MUSCULOSKELETAL	<input type="checkbox"/> Swollen Glands
<input type="checkbox"/> Drug Allergy	<input type="checkbox"/> Joint Pain	ENDOCRINE
NEUROLOGIC	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Thyroid Disease History
<input type="checkbox"/> Tremors	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Numbness	EAR / NOSE / THROAT	PSYCHOLOGY
<input type="checkbox"/> Stroke	<input type="checkbox"/> Infection	<input type="checkbox"/> Having feelings of depression?
<input type="checkbox"/> TIA	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Have attempted suicide in the past?
GASTROINTESTINAL	<input type="checkbox"/> Snoring	<input type="checkbox"/> Thoughts of harming yourself?
<input type="checkbox"/> Abdominal Pain	GENITOURINARY (Urine)	
<input type="checkbox"/> Nausea	<input type="checkbox"/> Incontinence (uncontrollable/leaking)	
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Painful Void (hurts to urinate)	
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Frequency (urinate often)	
<input type="checkbox"/> Appetite Loss	<input type="checkbox"/> Difficulty	
<input type="checkbox"/> Bloody Stool		
Additional Comments From Above:	Additional Comments From Above:	Additional Comments From Above:

Physician Signature: _____

Date: _____