

PATIENT HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date: _____ Occupation: _____

Past Illnesses

(check any illness you have had)

- _____ Asthma
- _____ Hay Fever
- _____ Emphysema
- _____ Tuberculosis (TB)
- _____ Kidney trouble
- _____ Heart trouble
- _____ High Blood pressure
- _____ High Cholesterol
- _____ Rheumatic fever
- _____ Heart murmur
- _____ Diabetes
- _____ Stroke
- _____ Cancer - Type: _____
- _____ Anemia
- _____ Arthritis
- _____ Gout
- _____ Abnormal pap smear
- _____ Stomach Ulcers
- _____ Seizures
- _____ Depression | Anxiety
- _____ Back problems
- _____ Bowel problems
- _____ Polyps of bowel
- _____ Thyroid Disease
- _____ Gallstones
- _____ Hepatitis
- _____ Liver problems
- _____ Bleeding problems
- _____ Alcohol problems
- _____ Drug addition
- _____ Hearing loss
- _____ Vision problems
- _____ Sexually transmitted disease
- _____ Other: _____

Immunizations

(check all and year received if known)

Received

- _____ Rubella
- _____ Measles
- _____ Tetanus
- _____ Phenmomia
- _____ Hepatitis
- _____ Influenza (flu shot)
- _____ Hepatitis B

Allergies

(check any you have & give the reaction)

- | | |
|------------------|----------------|
| _____ Penicillin | REACTION _____ |
| _____ Sulfa | _____ |
| _____ Aspirin | _____ |
| _____ Codine | _____ |
| _____ Bee Stings | _____ |
| _____ Other | _____ |

Surgery

(check any surgery you have had)

- _____ Hernia
- _____ Appendix
- _____ Tonsils
- _____ Gallbladder

Women Only

- _____ Uterus
- _____ Ovaries
- _____ Breast
- _____ D & C
- _____ Tubal
- _____ Other _____

Men Only

- _____ Testicular
- _____ Prostate
- _____ Vasectomy
- _____ Other _____

Hospitalizations

(List dates & reasons for all hospitalizations.)

DATE	REASON
_____	_____
_____	_____
_____	_____
_____	_____

Social History

(Circle any that apply.)

- Tobacco Use _____ Yes or No
- Amt/Type _____
- Drink Alcohol _____ Yes or No
- Amt/Type _____

Do you or have you used drugs? Yes or No

Amt/Type _____

Medications

(List any medications currently taking)

Include Prescriptions and Over the Counter

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Women Only

- Age of first period _____
- # of times pregnant _____
- # of live deliveries _____
- Date of last Pap smear _____
- Age periods stopped _____
- Birth control method - circle
- Pills _____ Condoms _____ IUD _____
- Sponge _____ Rhythm _____ Diaphragm _____
- Vasectomy _____ Hysterectomy _____

Men & Women

Do you consider yourself to be:

- _____ Heterosexual
- _____ Gay
- _____ Bisexual

Family History

Check the diseases that your parents, grandparents, aunts, uncles, brothers, or sisters have had or have.

- _____ Diabetes
- _____ Lung problems
- _____ Stroke
- _____ Cancer - type _____
- _____ Seizures
- _____ Heart disease
- _____ High blood pressure
- _____ Thyoid disease
- _____ Kidney problems
- _____ Other (list below) _____