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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"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | |
| Previous or referring doctor: | Date of last physical exam: | |

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

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Surgeries

| Year | Reason |
|------|--------|
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Other hospitalizations

| Year | Reason |
|------|--------|
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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

| Name the Drug | Strength | Times per day |
|---------------|----------|---------------|
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| | | |
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Allergies to medications

| Name the Drug | Reaction You Had |
|---------------|------------------|
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HEALTH HABITS AND PERSONAL SAFETY

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

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|------------------------|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------------------|-----------------------------------------|
| Exercise | <input type="checkbox"/> Sedentary (No exercise) | | | |
| | <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | |
| | <input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | |
| | <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | |
| Diet | Are you dieting? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | If yes, are you on a physician prescribed medical diet? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | # of meals you eat in an average day? | | | |
| Caffeine | <input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola | | | |
| | # of cups/cans per day? | | | |
| 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"/> 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 | |
| Women Only | Are you pregnant? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | If no, are you trying for a pregnancy? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Personal Safety | Do you live alone? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Do you have frequent falls? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Do you have vision or hearing loss? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
|-----------------|----------------------------------------------------------|-----------------------------|----------------------------------------------------------|----------------------------------------------------------|-----------------------------|
| Father | | | Siblings | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Mother | | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Children | <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 | | |

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"/> Eating or your appetite |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Circulation | <input type="checkbox"/> Other pain/discomfort |