Health History Questionnaire

Name: _____ Age: _____ Sex: M F

Reason for Visit: _____

Please Check Any Symptoms You Currently Have:

__ Recent Fever/Chills/Sweats
__ Unexplained Weight Loss
__ Trouble Swallowing
__ Chest Pain
__ Shortness of Breath
__ New/Changing Mole
__ Difficulty with Urination
__ Cough/Wheezing
__ Coughing Up Blood
__ Heartburn
__ Abdominal Pain
__ Nausea/Vomiting
__ Breast Mass/Discharge
__ Abnormal Vaginal Bleeding
__ Constipation
__ Diarrhea
__ Blood in Stool
__ Black Tarry Stool
__ Leg Swelling
__ Easy Bruising/Bleeding
__ Leg Pain While Walking

Medications/Dosages: _____

_____

_____

_____

Allergies Please Check One: Iodine: yes___ no___ Adhesive Tape: yes___ no___ Latex: yes___ no___
Other: _____

Screening/Diagnostic Test That You Have Had Done:

__ Colonoscopy __Echocardiogram __Stress Test __PSA __Mammogram

Medical History-Please Circle Current or Past Conditions:

Anemia	COPD/Asthma	Heart Attack	Liver Disease	Thyroid Problems
Bleeding Disorder	Diabetes	Hepatitis	Pneumonia	Ulcers
Breast Lump	Emphysema	Hypertension	Prostate Problems	
Cirrhosis	Heart Disease	Kidney Disease	Stroke	

Surgical History:

Cancer Surgery: type_____ year _____ Cholecystectomy/Gallbladder: year _____
Heart Bypass/Valve Replacement: year _____ Hysterectomy/Tubular Pregnancy: year _____
Hernia: type_____ _____year _____ Appendectomy: year _____
Other:_____ ____year _____ Other: _____ year _____

Family History-Please Circle any that Apply:

Breast Cancer	none	mother	father	sister	brother	grandmother	grandfather
Colon Cancer	none	mother	father	sister	brother	grandmother	grandfather
Thyroid Disease	none	mother	father	sister	brother	grandmother	grandfather

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

Social History:
Tobacco: _____ Packs Per Day: _____ Years: _____
Alcohol: _____ Drinks Per Day: _____ Years: _____
Exercise: _____ Type: _____ How Often: _____
Farthest walked at one time in the last month? _____
Any Symptoms?

Comprehensive Review of Systems-Please Circle any Current Conditions:

Dermatology
Rash
Moles
Hives
Itching
Hair loss
Lumps
Keloid Formation
Skin Cancer

Constitutional
Weight Loss
Weight Gain
Loss of Appetite
Fever
Weakness
Bleeding Problems
Claustrophobia

Gastroenterology
Nausea
Heartburn
Vomiting
Difficulty Swallowing
Abdominal Pain
Diarrhea
Change in Bowel Habits
Blood in Stool
Constipation

Musculoskeletal
Joint Stiffness
Leg Cramps
Joint Pain
Joint Swelling
Back Pain
Neck Pain
Muscle Aches
Metal in Body

Hematology
Easy Bruising
Swollen Glands
Fatigue
Anemia

Genitourinary Male
Difficulty Urinating
Hernia
Undescended Testicle
Kidney Disease
Urinary Tract Infection

Patient's Signature: _____ **Date:** _____