

Date: _____

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:	AGE:
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			
Primary Care Physician:		Referring Physician:		

Please list any physicians to whom you would like a report of your treatment sent:

PLEASE DESCRIBE THE REASON FOR YOUR VISIT TODAY

PLEASE LIST YOUR MEDICATIONS AND DOSAGES			
Medication Name	Strength (MG)	Times per day	Prescribing Physician

ALLERGIES TO MEDICATIONS	
Name of Drug	Reaction You Had

YES NO Are you allergic or sensitive to LATEX?

Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?	
	How many drinks per day? 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		

GENERAL

Please answering the following questions by checking the appropriate box and provide DETAILS for each item where you checked YES.

DETAILS		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you had heart disease (e.g. rheumatic fever, heart attack, abnormal rhythm, heart murmur, mitral valve prolapse)?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you routinely take antibiotics before dental work or surgery?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you had high blood pressure?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you had lung disease (e.g., asthma, emphysema, tuberculosis, pneumonia)?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you had urinary tract problems (e.g., infection, kidney stones, prostate problems, bloody urine)?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you had gastrointestinal problems (e.g., heart burn, ulcer, chronic diarrhea or constipation, hemorrhoids, piles)?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you had any recent change in bowel habits or blood in stools?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you ever had cancer? If so, please describe how it was treated.	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you had any change in appetite or any weight loss not attributed to dieting?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you had any jaundice or liver disease?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you ever had a blood transfusion?	

GENERAL CONTINUED			DETAILS
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have you had any clotting or bleeding abnormalities (e.g., anemia, sickle cell anemia, leukemia) or lymph gland disorders? Do you bruise or bleed easily?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Are you infected with HIV (the Aids virus)?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have you had any exposure to HIV or Hepatitis?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have you ever used IV drugs?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have you had arthritis? Do you have any pain, stiffness or swelling in any muscles or joints?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do you have numbness, tingling or weakness in any part of your body?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have you ever had any fits, convulsions or seizures? Have you ever fainted?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have you ever had a stroke or any other neurological disease?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have you had head trauma, broken bones, and accidents?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do you have diabetes?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have you had any endocrine disorder (e.g., thyroid or adrenal gland problems)?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have you or any blood relative ever had an adverse reaction to or problem with anesthesia?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have you ever had any venereal or sexually transmitted disease?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do you have a history of depression or other psychiatric illness?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Are you currently taking Aspirin or blood thinners?	

PLEASE LIST ANY FAMILY HISTORY OF CANCER			
TYPE OF CANCER	FAMILY MEMBER	AGE:	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
		AGE:	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
		AGE:	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
		AGE:	<input type="checkbox"/> Living <input type="checkbox"/> Deceased

PLEASE LIST ANY PRIOR SURGERY, DATE, AND THE TYPE OF ANESTHESIA		
DATE	TYPE OF OPERATION	TYPE OF ANESTHESIA

WOMEN ONLY		
Age at onset of menstruation:	Date of last menstruation:	
Number of pregnancies	Number of live births	Age at first pregnancy
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Are you pregnant or breastfeeding?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Did you ever Nurse? How Long?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have you ever taken birth control pills or hormone therapy? When?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Are you taking hormone therapy now? What kind?
Have you ever had: <input type="checkbox"/> breast Surgery, <input type="checkbox"/> Breast implants, <input type="checkbox"/> breast reduction or <input type="checkbox"/> breast biopsy? Please Describe.		
Have you ever had: <input type="checkbox"/> breast tenderness, <input type="checkbox"/> lumps, <input type="checkbox"/> nipple discharge or <input type="checkbox"/> any other breast problems? Please Describe.		