



Date:

HEALTH HISTORY QUESTIONNAIRE

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		
Reason for visit:	Referring Doctor:	

PERSONAL HEALTH HISTORY

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

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

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<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		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

SOCIAL HISTORY

Smoking? yes no Number of packs per day _____ Number of years used _____

Alcohol? yes no Number of drinks per week _____

Drugs? yes no

FEMALE HISTORY ONLY (MALES DO NOT NEED TO FILL THIS PORTION OUT)

Birth Control Use/Duration	
Hormone Replacement Therapy/Duration	
Fertility Treatment/Duration	
Age of first period	
Date of last period	
Age of onset of menopause	
Surgical Term/Menses	
Pregnancies	
Ages of children	
Miscarriage/term	
Live births	
Number of months breastfeeding	
Number of children breastfed	

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"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

PHYSICIANS

Please list below any physicians that you are being treated by currently, and with whom you would like us to send any reports or findings to:

Primary:

Family Doctor:

Internist:

Ob/Gyne:

Cardiologist:

Medical Oncologist:

Radiation Oncologist:

Surgeon:

Other: