PATIENT HEALTH HISTORY QUESTIONNAIRE

The following information is very important to your plan of care.
Please take time to fully and completely fill out this important information.
We are counting on you. Please complete every section. Do not leave any blanks.

Name: ___________________________ **DOB:** ___________ **Age:**____ **Date:** ___________ **Appt.**___________

Gender: M F O **Marital status:** Single Married Partnered Widowed Separated Divorced

Family Dr. ___________________________________ **Requesting Dr.** ____________________________________

Other treating physicians: ____

What will we be seeing you for? ____

Spoken language: ____________________________

Preferred Language for Medical Information: ____

YOUR PAST MEDICAL HISTORY

Do you have now, or have you ever had any of the following? Mark all that apply.

□ Abdominal Aortic Aneurysm	□ Gallbladder disease	□ Osteoporosis
□ Alzheimer's disease	□ Glaucoma	□ Pacemaker
□ Anemia	□ Gout	□ w/Defibrillator
□ Anxiety	□ Heart Attack/MI	□ Prostate problems
□ Arthritis	□ stent(s)	□ Psychiatric disease
□ Asthma	□ Heart Murmur	□ Pulmonary Embolus
□ Back disorder	□ Heartburn: □ occasional	□ Rheumatoid Arthritis
□ Bleeding disorder	□ GERD	□ Serious Infection
□ Blood Clots/DVT	□ Hepatitis: □ A	□ Sleep Apnea □CPAP
□ Cancer (location)	□ B	□ Stroke
□ Carotid Artery disease	□ C	□ TIA
□ Crohn's disease	□ High Blood Pressure	□ Thyroid disease
□ Irritable Bowel Syndrome	□ High Cholesterol	□ Ulcers
□ Celiac disease	□ HIV/AIDS	□ Vascular disease/Stents
□ COPD	□ Irregular Heart Rate	□ heart
□ Congestive Heart Failure (CHF)	□ Kidney disease	□ other
□ Coronary Artery disease	□ Lactose Intolerance	□ Venereal disease/STD
□ Diabetes: □ Type I	□ Lung disease	
□ Type II	□ Supplemental oxygen	□ Other:
□ Pre-diabetic	□ Malignant Hyperthermia	
□ Depression	□ Migraines	
□ Emphysema	□ MRSA/MSSA	
□ Epilepsy/Seizure disorder	□ Neuropathy	

Have you ever had SURGERY? ☐Yes—please explain ☐ No **Year** **Hospital**

____ ______ ____________

____ ______ ____________

____ ______ ____________

Do you have any IMPLANTED MEDICAL DEVICES? ☐ No ☐ Yes – please explain

YEAR: ______________ HOSPITAL: ____

Please provide as many details as possible; include make and model numbers from your implant cards, if applicable.

____

____

____

Have you ever been HOSPITALIZED? ☐Yes—please explain ☐ No

____ ______ ____________

____ ______ ____________

____ ______ ____________

Assistive Devices: ☐ cane ☐ walker ☐ crutches ☐ wheelchair ☐ other____________________

MEDICATIONS: (Please Include Dosage) ☐ **No Active Medications**

Do you take any blood thinners? ☐Yes ☐ No

PRESCRIPTION Medications	DOSE	DIRECTIONS	PURPOSE

Over the counter medications: (like Aspirin, Ibuprofen, Naproxen, etc)

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Vitamin, Mineral, and Herbal Supplements:

________________ ________ ________________ ________________
________________ ________ ________________ ________________
________________ ________ ________________ ________________
________________ ________ ________________ ________________
________________ ________ ________________ ________________
________________ ________ ________________ ________________

Are you ALLERGIC to any of the following? □ No (if yes, please explain your reaction)

□ **SHELLFISH** ________________ □ **EGGS** ________________ □ **LATEX**________________
□ **IODINE** ________________ □ **POULTRY** ________________ □ **METAL**________________
□ **X-RAY DYE**________________ □ **FEATHERS**________________ □ **NICKEL**________________
□ **Bee Stings** ________________ □**Seasonal/Environmental** ________________________________

DRUG ALLERGIES or ADVERSE REACTIONS: □ **No Known drug allergies**

ALLERGY	REACTION	ALLERGY	REACTION

FAMILY HISTORY – Has anyone in your family had any of the following problems?

No known family history □ **Unaware of family history details** □

Disease	Mother	Father	Brothers	Sisters	Daughters	Sons
High blood pressure/ Hypertension						
Heart Attack/ Heart surgery						
Diabetes						
Stroke						
Cancer (type)						
Osteoporosis						
Thyroid problems						
Problems with anesthesia						
Malignant hyperthermia						
Blood clots/Blood Diseases						
Other -						

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SOCIAL HISTORY – Please mark every area

Occupation:____________________________________ □ **Right Hand Dominant** □ **Left Hand Dominant**

Personal Habits:…………………	No	Yes – please explain (type/amount/ frequency/quit date)
Use Tobacco products currently	□	□ ____________________________________
Used Tobacco products in the past	□	□ ____________________________________
Use Alcohol products currently	□	□ ____________________________________
Used Alcohol products in the past	□	□ ____________________________________
Use illegal drugs currently	□	□ ____________________________________
Used illegal drugs in the past	□	□ ____________________________________

REVIEW OF SYSTEMS

Have you been troubled with any of the following symptoms within the last 4 – 6 weeks?

General
□No □Yes Fever
□No □Yes Sweats

Skin
□No □Yes Itching
□No □Yes Rash
□No □Yes Slow healing wounds

Hematologic
□No □Yes Easy bruising
□No □Yes Easy bleeding
□No □Yes Hard to stop bleeding

Eyes
□No □Yes Blurred Vision
□No □Yes Changing Vision
□No □Yes Double Vision
□No □Yes Wear glasses
□No □Yes Wear contacts

Neurologic
□No □Yes Numbness
□No □Yes Tingling
□No □Yes Headaches
□No □Yes Weakness

Allergy
□No □Yes Hives
□No □Yes Seasonal symptoms
□No □Yes Sneezing
□No □Yes Nasal congestion

Cardiovascular
□No □Yes Chest pain
□No □Yes Chest pressure
□No □Yes Ankle swelling
□No □Yes Irregular heartbeat

Mental Health
□No □Yes Insomnia
□No □Yes Anxiety
□No □Yes Depression
□No □Yes Memory loss
□No □Yes Suicidal thoughts

Nutrition
□No □Yes Special diet
□No □Yes Weight loss
□No □Yes Weight gain
□No □Yes Change in appetite

Respiratory
□No □Yes Cough
□No □Yes Shortness of Breath
□No □Yes Wheezing

Endocrine
□No □Yes Excessive urination
□No □Yes Excessive thirst
□No □Yes Fatigue
□No □Yes Heat or cold intolerance

Is there someone in your life who is physically or emotionally harming you? □No □Yes

Patient Signature: __________________________________ Date: ___________________

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