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 your ever had SURGERY? □Yes—please explain □ No Year Hospital

Have your 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)

Vitamin, Mineral, and Herbal Supplements:

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

□ **SHELLFISH** _____ □ EGGS _____ □ LATEX_____

□ **IOD**INE _____ □ 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 -						

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	□	□ _____

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REVIEW OF SYSTEMS

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

General		Skin		Hematologic	
Fever	□No □Yes	Itching	□No □Yes	Easy bruising	□No □Yes
Sweats	□No □Yes	Rash	□No □Yes	Easy bleeding	□No □Yes
		Slow healing wounds	□No □Yes	Hard to stop bleeding	□No □Yes
Eyes		**Neurologic**		**Allergy**	
Blurred Vision	□No □Yes	Numbness	□No □Yes	Hives	□No □Yes
Changing Vision	□No □Yes	Tingling	□No □Yes	Seasonal symptoms	□No □Yes
Double Vision	□No □Yes	Headaches	□No □Yes	Sneezing	□No □Yes
Wear glasses	□No □Yes	Weakness	□No □Yes	Nasal congestion	□No □Yes
Wear contacts	□No □Yes				
Cardiovascular		**Mental Health**		**Nutrition**	
Chest pain	□No □Yes	Insomnia	□No □Yes	Special diet	□No □Yes
Chest pressure	□No □Yes	Anxiety	□No □Yes	Weight loss	□No □Yes
Ankle swelling	□No □Yes	Depression	□No □Yes	Weight gain	□No □Yes
Irregular heartbeat	□No □Yes	Memory loss	□No □Yes	Change in appetite	□No □Yes
		Suicidal thoughts	□No □Yes		
Respiratory		**Endocrine**			
Cough	□No □Yes	Excessive urination	□No □Yes		
Shortness of Breath	□No □Yes	Excessive thirst	□No □Yes		
Wheezing	□No □Yes	Fatigue	□No □Yes		
		Heat or cold intolerance	□No □Yes		

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

Patient Signature: _____ Date: _____

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