

# HEALTH HISTORY QUESTIONNAIRE

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender:  Male  Female

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Race: \_\_\_\_\_ Emergency Contact Person: \_\_\_\_\_ Number: \_\_\_\_\_

## Chief Complaint and Present Illness

Chief Complaint: \_\_\_\_\_

If symptoms include Pain, check the boxes that best describe:  Aching  Boring  Burning  
 Cramping  Crushing  Constricting  Deep  Dull  Gnawing  Heavy  Knife Like  Lancinating  
 Piercing  Pounding  Pressure Like  Sharp  Shooting  Stabbing  Tearing  Tender  Throbbing  
 Tight  Other \_\_\_\_\_

Date or Time Since Symptoms Began: \_\_\_\_\_

Location of Symptoms: \_\_\_\_\_

Please mark all areas of symptoms on the diagram

Onset manner of symptoms:  Gradual  Sudden  Injury

Frequency of Symptoms: \_\_\_\_\_

Rare  Occasional  Intermittent  Frequent  Constant

Severity of Pain:  Minimal  Mild  Moderate  Severe

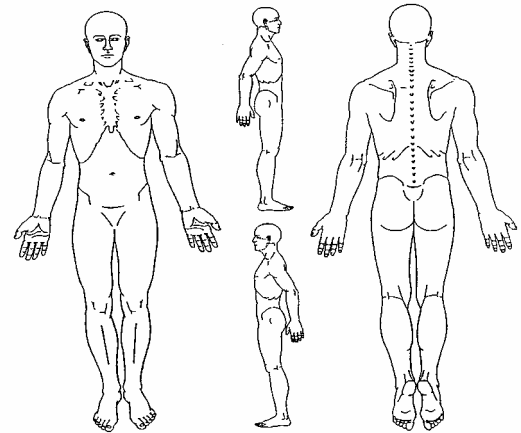
How long do your symptoms usually last: \_\_\_\_\_

How did symptoms start: \_\_\_\_\_

How have symptoms progressed:  Improved  Unchanged  Getting Worse

What brings on symptoms: \_\_\_\_\_ What makes symptoms worse: \_\_\_\_\_

What relieves symptoms: \_\_\_\_\_



Rate your pain on a scale of 1-10 with 10 being the worst:

## Medications

Please list all medications that you are currently taking, **both prescription and over the counter**

Medication Name	Dosage	Frequency	Who Prescribed Medication

## Past Medical History

Please provide a list and history of all past medical conditions: Ex; Asthma, Diabetes, High blood pressure etc

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Provide a complete list of all illnesses, injuries, surgeries, and hospitalization. (Use back of page if necessary)

List Illnesses, Surgeries, and Hospitalizations	Date	Treatment

Check any childhood diseases that you have had:

Chicken Pox  Measles  Mumps  Polio  Rheumatic Fever  Rubella  Scarlet Fever  None

Have you ever had a Blood Transfusion:  Yes  No

Have you ever been exposed to a Sexually Transmitted Disease:  Yes  No If yes, list disease: \_\_\_\_\_

## Allergies

List all allergies including medications and the reaction. If none, write none.

List Allergies	Reaction you had

## Family History

	Status	Age	Illnesses	Cause of Death
Father	<input type="checkbox"/> Living			
	<input type="checkbox"/> Deceased			
	<input type="checkbox"/> Unknown			
Mother	<input type="checkbox"/> Living			
	<input type="checkbox"/> Deceased			
	<input type="checkbox"/> Unknown			

	Number	List any illnesses
Siblings		
Children		

## Social History

Marital Status:  Single  Engaged  Married  Separated  Divorced  Spouse Deceased

Occupation: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

Tobacco Use:  Never  Current  Discontinued - Type: \_\_\_\_\_ Quantity: \_\_\_\_\_ Years: \_\_\_\_\_

Alcohol Use:  Never  Beer(s) \_\_\_/Week  Liquor \_\_\_/Week  Wine \_\_\_/Week  Recovering Alcoholic

Caffeine: \_\_\_ Coffee \_\_\_ Tea \_\_\_ Soda

Exercise:  Not Exercising  Exercising \_\_\_ Times per week - Type of exercise: \_\_\_\_\_

Illicit Drug Usage:  Never  Past History  Current. Please list drugs used \_\_\_\_\_  
 Drug/Alcohol Abuse Treatment  Yes  No: If yes,  In-Patient  Out-Patient  Both

## Review of Systems

Please check all symptoms or illnesses that you have **currently**.

<p style="text-align: center;"><b>General</b></p> <input type="checkbox"/> Decreased Activity <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Chills <input type="checkbox"/> Decreased Energy <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Sweating <input type="checkbox"/> Weight Change <input type="checkbox"/> None of above	<p style="text-align: center;"><b>Eyes</b></p> <input type="checkbox"/> Discharge <input type="checkbox"/> Dry <input type="checkbox"/> Itching <input type="checkbox"/> Drooping <input type="checkbox"/> Redness <input type="checkbox"/> Swelling <input type="checkbox"/> Visual Difficulties <input type="checkbox"/> Vision Loss <input type="checkbox"/> None of above	<p style="text-align: center;"><b>Ears/Nose/Mouth/Throat</b></p> <input type="checkbox"/> Congestion <input type="checkbox"/> Discharge <input type="checkbox"/> Earache <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hearing Sensitivity <input type="checkbox"/> Pain <input type="checkbox"/> Popping <input type="checkbox"/> Ringing <input type="checkbox"/> Vertigo <input type="checkbox"/> None of Above	<p style="text-align: center;"><b>Nose</b></p> <input type="checkbox"/> Altered Smell <input type="checkbox"/> Bleeding <input type="checkbox"/> Congestion <input type="checkbox"/> Discharge <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Sinus Pressure <input type="checkbox"/> Snoring <input type="checkbox"/> None of above
<p style="text-align: center;"><b>Mouth</b></p> <input type="checkbox"/> Altered Sense of Taste <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Burning Tongue <input type="checkbox"/> Lesion <input type="checkbox"/> Mass <input type="checkbox"/> Sore <input type="checkbox"/> Pain <input type="checkbox"/> Gum Problems <input type="checkbox"/> None of above	<p style="text-align: center;"><b>Throat</b></p> <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore Throat <input type="checkbox"/> Lesion <input type="checkbox"/> Mass <input type="checkbox"/> Cough <input type="checkbox"/> Apnea <input type="checkbox"/> Snoring <input type="checkbox"/> Dryness <input type="checkbox"/> Reflux <input type="checkbox"/> None of above	<p style="text-align: center;"><b>Lungs/Respiratory</b></p> <input type="checkbox"/> Cough <input type="checkbox"/> Coughing Blood <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sputum <input type="checkbox"/> Wheezes <input type="checkbox"/> None of above	<p style="text-align: center;"><b>Heart/Cardiac</b></p> <input type="checkbox"/> Chest Discomfort <input type="checkbox"/> Chest Pain <input type="checkbox"/> Chest Pressure <input type="checkbox"/> Cold Hands/Feet <input type="checkbox"/> Blue Extremities <input type="checkbox"/> Difficulty Breathing with Exercise <input type="checkbox"/> Extremity Swelling <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Palpitations <input type="checkbox"/> Increase Heart Rate <input type="checkbox"/> None of above
<p style="text-align: center;"><b>Digestive/Gastrointestint</b></p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Bloating <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Food Intolerance <input type="checkbox"/> Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Nausea <input type="checkbox"/> Regurgitation <input type="checkbox"/> Abnormal Stool <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Vomiting <input type="checkbox"/> None of above	<p style="text-align: center;"><b>Genitourinary</b></p> <input type="checkbox"/> Bloody Urine <input type="checkbox"/> Frequency <input type="checkbox"/> Bed-Wetting <input type="checkbox"/> Incontinence <input type="checkbox"/> Odor <input type="checkbox"/> Pain with Urination <input type="checkbox"/> Passing Stones <input type="checkbox"/> Abnormal Stream <input type="checkbox"/> Abnormal Urine Appearance <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Genital Lesion <input type="checkbox"/> Libido Changes <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Sexual Dysfunction <input type="checkbox"/> None of above	<p style="text-align: center;"><b>Female Only</b></p> <p><b>Vaginal</b></p> <input type="checkbox"/> Burning <input type="checkbox"/> Discharge <input type="checkbox"/> Dryness <input type="checkbox"/> Irritation <input type="checkbox"/> Itching <input type="checkbox"/> Lesions <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Premenstrual Sympt <input type="checkbox"/> Menstrual Symptom <ul style="list-style-type: none"> <li><input type="checkbox"/> Irregular Bleeding</li> <li><input type="checkbox"/> Cramps</li> <li><input type="checkbox"/> Pain</li> </ul> <input type="checkbox"/> Menopausal <input type="checkbox"/> None of above Date of last Menstrual Period: _____	<p style="text-align: center;"><b>Musculoskeletal</b></p> <p><b>Joint</b></p> <input type="checkbox"/> Inflammation <input type="checkbox"/> Redness <input type="checkbox"/> Pain <input type="checkbox"/> Limited Motion <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Tenderness <input type="checkbox"/> Weakness <p><b>Muscle</b></p> <input type="checkbox"/> Atrophy <input type="checkbox"/> Cramps <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Weakness <input type="checkbox"/> None of above

## Review of Systems Continued

Please check all symptoms or illnesses that you have **currently**.

<p style="text-align: center;">Neurological</p> <input type="checkbox"/> Blackouts <input type="checkbox"/> Balance Problems <input type="checkbox"/> Concentration <input type="checkbox"/> Confused/Disoriented <input type="checkbox"/> Coordination Loss <input type="checkbox"/> Drowsiness <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Gait Abnormality <input type="checkbox"/> Headache <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures <input type="checkbox"/> Speech Changes <input type="checkbox"/> Tremors <input type="checkbox"/> None of above	<p style="text-align: center;">Skin</p> <input type="checkbox"/> Color Changes <input type="checkbox"/> Texture Changes <input type="checkbox"/> Itching <input type="checkbox"/> Blisters <input type="checkbox"/> Sores <input type="checkbox"/> Mole Changes <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Hair Changes <input type="checkbox"/> Nail Changes <input type="checkbox"/> None of above	<p style="text-align: center;">Blood/Lymphatics</p> <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Abnormal Bruising <input type="checkbox"/> Painful Lymph Nodes <input type="checkbox"/> Tender Lymph Nodes <input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> None of above	<p style="text-align: center;">Psychiatric</p> <input type="checkbox"/> Abuse Victim <input type="checkbox"/> Personality Change <input type="checkbox"/> Compulsiveness <input type="checkbox"/> Depression <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Irritability <input type="checkbox"/> Hostility <input type="checkbox"/> Hyperactive <input type="checkbox"/> Nervousness <input type="checkbox"/> Memory Problems <ul style="list-style-type: none"> <li><input type="checkbox"/> Short Term Loss</li> <li><input type="checkbox"/> Long Term Loss</li> </ul> <input type="checkbox"/> Mood Swings <input type="checkbox"/> Anxiety <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> None of above
<p style="text-align: center;">Endocrine</p> <input type="checkbox"/> Hair Loss <input type="checkbox"/> Voice Changes <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Excessive Urination <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> None of above			

By signing below I certify that that above information is true to the best of my knowledge and I consent for the provider to evaluate and recommend treatment for the condition or conditions present above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

How did you find out about our office? \_\_\_\_\_