

PATIENT HISTORY QUESTIONNAIRE

DATE: _____

NAME: _____ **DATE OF BIRTH:** _____

FAMILY HISTORY: Has any **BLOOD** relative had the following? If so, please indicate that individual's relationship to you (i.e., Mother, Father, etc.)

_____ Mental Illness	_____ High Blood Pressure
_____ Heart Disease	_____ Diabetes
(If heart attack, indicate age of first onset)	
_____ Glaucoma	_____ Cancer
_____ Suicide	_____ Stroke
_____ Alcoholism	_____ Colon Polyps
_____ High Cholesterol	_____ Other

SOCIAL HISTORY:

Occupation: _____	Spouse: _____
Do you smoke? _____	If so, how much and for how long? _____
If a former smoker, when did you quit? _____	
Do you drink Alcohol? _____	Average Use? _____
Diet (Meals/Day) _____	Do you avoid any foods? _____
Exercise: (Daily/Weekly) _____	Do you consider yourself at risk for AIDS? _____
Do you feel safe at home? _____	Seat Belts? _____

PERSONAL HISTORY: Check any illness or condition **YOU** have had or currently have:

_____ Rheumatic Fever	_____ Blood in Stools	_____ Diabetes	_____ Anemia
_____ Hemorrhoids	_____ Thyroid or Goiter	_____ Cancer	_____ Arthritis
_____ High Cholesterol	_____ Kidney Stones/Disease	_____ Osteoporosis	_____ Depression
_____ Syphilis/Gonorrhea	_____ Herpes/Genital Sores	_____ Pneumonia	_____ Hay Fever
_____ Weight change	_____ Epilepsy/Seizures	_____ Tuberculosis	_____ Cough
_____ Asthma	_____ Passing Out	_____ Gallstones	_____ AIDS/HIV

Positive

_____ Shortness of breath	_____ Ulcers/Heartburn	_____ Chest Pain	_____ Easy Bruising
_____ Hepatitis/Jaundice	_____ Coughing Blood	_____ Acute MI	_____ Heart trouble
_____ One sided weakness	_____ Radiation Therapy	_____ Blood clotting problems	
_____ Other serious illness	_____ Frequent leg Cramps	_____ Glaucoma/Vision problems	
_____ Loss of Bladder Control		_____ Unexplained weight loss	

Have you had a problem with substance abuse in the past: _____

Do you have any occupational exposure risks, i.e. sunlight, asbestos, loud noise, toxic chemicals or fumes? _____

PATIENT NAME: _____ **Date of Birth:** _____

CURRENT MEDICATION: see attached list

Name of Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____

ALLERGIES:

List all Medicine Allergies: _____

IMMUNIZATION HISTORY (with dates if possible)

Td _____ Mumps, Measles, Rubella (MMR) _____
Pneumonia _____ Hepatitis B _____

PAST SURGICAL HISTORY:

(List surgery and what year it was done)

1. _____ 2. _____
3. _____ 4. _____

LIST ALL OTHER HOSPITALIZATIONS (without surgery) AND DATES:

1. _____ 2. _____
3. _____ 4. _____

FEMALE PATIENTS ONLY:

Date of Last Menstrual Period: _____ Date of last Mammogram: _____

Date of last Pap Smear: _____ Do you examine your breasts monthly? _____

Are you immune to German Measles (Rubella)? _____ Number of Pregnancies: _____

Number of live births: _____ Age at First Menstrual Period: _____

Age at first Pregnancy: _____

Do you have a history of the following? Abnormal Pap _____ Vaginal Discharge _____ Irregular Menses _____

Fibroids _____ Endometriosis _____

Form of Contraception: _____

MALE PATIENTS ONLY:

How many times per night do you get up to urinate?

Do you have any of the following?

_____ Prostate Trouble _____ Decreased Urinary Stream

Last prostate exam: _____ Self testicle exams? _____

LEARNING ASSESSMENT:

Primary Language: _____ English _____ Spanish: _____ Other: _____

Level of Education: _____

CULTURAL/RELIGIOUS ASSESSMENT:

Do you have any religious or cultural health beliefs that are important for us to know? If you do, please describe:

ABUSE ASSESSMENT:

Are you currently being physically, sexually, or mentally abused? If so, please describe: _____

DO YOU HAVE A LIVING WILL? _____

Physician Signature: _____

Review Dates:

_____	_____	_____	_____	_____	_____
Initials:	_____	_____	_____	_____	_____