HEALTH HISTORY QUESTIONNAIRE

Date: _____

First Name: _____ Middle: _____ Last: _____

SSN: ____-_____-_____ Date of Birth: _____/_____/_____ Gender: □ Male □ Female

Phone: (H) _____ (W) _____ (C) _____

Race: _____ Emergency Contact Person: _____ Number: _____

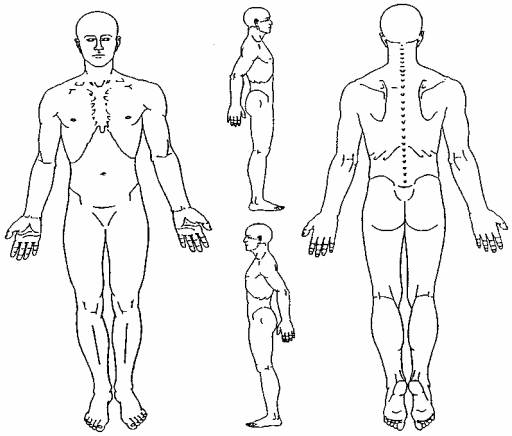
Chief Complaint and Present Illness

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:_____

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

How did symptoms start: _____

How have symptoms progressed: ☐Improved ☐Unchanged ☐Getting Worse

What brings on symptoms: _____ What makes symptoms worse: _____

What relieves symptoms: _____

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

_____

_____

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	☐Living ☐Deceased ☐Unknown			
Mother	☐Living ☐Deceased ☐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**.

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

Review of Systems Continued

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

Neurological	Skin	Blood/Lymphatics	Psychiatric
☐ Blackouts ☐ Balance Problems ☐ Concentration ☐ Confused/Disoriented ☐ Coordination Loss ☐ Drowsiness ☐ Dizziness ☐ Fainting ☐ Gait Abnormality ☐ Headache ☐ Lightheadedness ☐ Loss of Consciousness ☐ Loss of Sensation ☐ Loss of Memory ☐ Muscle Weakness ☐ Paralysis ☐ Seizures ☐ Speech Changes ☐ Tremors ☐ None of above	☐ Color Changes ☐ Texture Changes ☐ Itching ☐ Blisters ☐ Sores ☐ Mole Changes ☐ Rashes ☐ Hives ☐ Hair Changes ☐ Nail Changes ☐ None of above Endocrine ☐ Hair Loss ☐ Voice Changes ☐ Excessive Thirst ☐ Excessive Hunger ☐ Excessive Urination ☐ Heat Intolerance ☐ Cold Intolerance ☐ None of above	☐ Abnormal Bleeding ☐ Prolonged Bleeding ☐ Abnormal Bruising ☐ Painful Lymph Nodes ☐ Tender Lymph Nodes ☐ Swollen Lymph Nodes ☐ None of above	☐ Abuse Victim ☐ Personality Change ☐ Compulsiveness ☐ Depression ☐ Eating Disorder ☐ Irritability ☐ Hostility ☐ Hyperactive ☐ Nervousness ☐ Memory Problems o Short Term Loss o Long Term Loss ☐ Mood Swings ☐ Anxiety ☐ Sleep Problems ☐ Suicidal Thoughts ☐ 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? _____