

# HEALTH HISTORY QUESTIONNAIRE | 2008

All questions contained in this questionnaire are protected by privacy acts under HIPPA and will become part of your medical record. Fill in the blank or circle appropriate answer. You may continue answers on the last page (4)

Today's Date:

Name (Last, First, M.I.):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
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**Marital status:**    Single    Partnered    Married    Separated    Divorced    Widowed

### PERSONAL HEALTH HISTORY

**Childhood illness:**    Measles    Mumps    Rubella    Chickenpox    Rheumatic Fever    Polio

Please indicate current vaccinations and DATE received

- |  |  |
|--|--|
| <input type="checkbox"/> Tetanus or TET/DIP      | <input type="checkbox"/> Pneumonia                     |
| <input type="checkbox"/> Hepatitis (series of 3) | <input type="checkbox"/> Chickenpox/Shingles Shot      |
| <input type="checkbox"/> Influenza               | <input type="checkbox"/> MMR (Measles, Mumps, Rubella) |

**List any medical problems that other doctors have diagnosed or circle applicable items on list.**

- |                     |                  |             |                     |
|---------------------|------------------|-------------|---------------------|
| High Blood Pressure | Heart Disease    | Diabetes II | Atrial Fibrillation |
| Hypothyroidism      | High Cholesterol | COPD        | Asthma              |
| Peripheral Vascular | Arthritis        |             |                     |

**Surgeries and Procedures (Please circle any that apply and complete additional information as indicated)**

Year/Doctor		Year/Doctor	
	Carotid Endarterectomy (remove Plaque from Neck Vessels)		Endoscopy of Esophagus/stomach/Duodenum (EGD)
	Thyroidectomy --   Partial   Complete		Colonoscopy (findings?)   Polyps   Diverticulosis   IBS Chron's
	Coronary Artery Bypass   # of vessels		Cholecystectomy (Gallbladder Removed)   OPEN   Laparoscopic
	Cardiac Catheterization   Stent   YES   NO		Gastric Bypass   Type:
	Pacemaker or Automatic Implanted Defibrillator (circle)		Appendectomy
	Aortic Aneurysm Repair		Hysterectomy   Abdominal   Vaginal (THIS UTERUS only, see below)
	Vascular BYPASS (specify location):		Ovaries and Tubes   Left   Right   Both
	Breast Surgery: Mastectomy   Lumpectomy   Biopsy (non Cancer)		Tubal Ligation (sterilization)
	Chest Surgery:		Bladder (specify what type)
	Kidney Surgery:		Prostate: TUNA   TURP   OTHER:
	Hip Replacement:   LEFT   RIGHT		Cataracts:   LEFT   RIGHT
	Knee Replacement:   LEFT   RIGHT		Plastic Surgery (please indicate):
	Amputations:		
	OTHER:		

Testing in last two years. Circle test and area examined if it applies to you.

CT (computed Tomography)   Head   Chest   Abdomen   Pelvis	DEXA Bone scan for bone mass
MRI (circle) Head   Neck   Abdomen   OTHER:	Nuclear Medicine Scan

**Other hospitalizations in last 2 years (add additional information on last page)**

Year	Reason	Hospital

<b>Have you ever had a blood transfusion?</b>	<b>If yes, what year:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Have you ever had radiation therapy?</b>	<b>If yes, indicate reason:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Have you ever had a blood clot in your legs or lungs?</b>	<b>If yes, what year:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

See next page for additional questions

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<b>Allergies or intolerance to Medications? Please list the drug and make sure you are specific about your reaction. List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers eye drops, and nasal sprays. List additional allergies on other page</b>		
Name the Drug (Brand and Generic)	Reaction You Had	
<b>Current Medications (IF PILL BOTTLES ARE BROUGHT TO THE VISIT YOU DO NOT NEED TO COMPLETE THIS SECTION EXCEPT FOR OVER THE COUNTER AND HERBAL MEDICATIONS)</b>		
Name the Drug (BRAND and Generic)	Strength/dose/form	How and when you take the medications

## HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE CONFIDENTIAL IN COMPLIANCE WITH PRIVACY POLICIES					
<b>The amount of exercise you get on a weekly basis is _____ (please check appropriate answer)</b>	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf) <input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
<b>Are happy with your weight?</b>	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	Indicate the # of meals you eat in an average day.				
<b>How many Caffeinated drinks do you consume?</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	OTHER:
	# of cups/cans per day?				
<b>Do you consume alcoholic beverages? Please answer questions to the best of your ability.</b>	If yes, what kind? Circle all that apply.      Beer      Wine      Mixed drinks      Coolers      Other:				
	How many servings per week?		How many servings per week?		
	Are you concerned about the amount you drink?		Have you ever experienced blackouts?		
	Have you considered stopping?		Are you prone to "binge" drinking?		
	Do you drive after drinking?				
<b>Do you now or have you ever smoked or chewed tobacco? FILL in the blanks.</b>	I smoke cigarettes:      packs per day      # years		I quit in      , I smoked      packs per day for      years		
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	Are you interested in quitting?				

<b>Personal Questions related to your sexual health.</b>	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you or your wife trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy how are you preventing pregnancy?		
	Any discomfort with intercourse, such as PAIN or Dryness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Any problems with frequency or loss of interest in intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

See next page for additional question

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<i>Questions about your health and safety.</i>	Do you live alone?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you have frequent falls?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you wear glasses, contacts, hearing aids or dentures?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Are you a organ donor?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<i>Questions about your wishes.</i>	Do you have an Advance Directive or Living Will? If yes, please furnish a copy for your record.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If you do not, would you like information on the preparation of these? If yes, please ask our staff or check our website.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Have you designated a Healthcare Surrogate? If yes, please furnish a copy of your designation for your records.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Are you an organ donor?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

## FAMILY HEALTH HISTORY (PLEASE COMPLETE TO THE BEST OF YOUR ABILITY)

		AGE <i>(present, or age at death)</i>	HEALTH PROBLEMS			AGE <i>(present, or age at death)</i>	HEALTH PROBLEMS
<b>Father</b>				<b>Children</b>	<input type="checkbox"/> M		
					<input type="checkbox"/> F		
<b>Mother</b>					<input type="checkbox"/> M		
					<input type="checkbox"/> F		
<b>Siblings</b>	<input type="checkbox"/> M			<input type="checkbox"/> M			
	<input type="checkbox"/> F			<input type="checkbox"/> F			
	<input type="checkbox"/> M			<input type="checkbox"/> M			
	<input type="checkbox"/> F			<input type="checkbox"/> F			
	<input type="checkbox"/> M			<b>Grandmother</b>			
	<input type="checkbox"/> F			<i>Maternal</i>			
	<input type="checkbox"/> M			<b>Grandfather</b>			
	<input type="checkbox"/> F			<i>Maternal</i>			
<input type="checkbox"/> M			<b>Grandmother</b>				
<input type="checkbox"/> F			<i>Paternal</i>				
<input type="checkbox"/> M			<b>Grandfather</b>				
<input type="checkbox"/> F			<i>Paternal</i>				

## WOMEN ONLY

How old were you when you started menstruating?	Date of last menstruation:
How many pregnancies _____ How many live births _____	Are you pregnant or breastfeeding?
Have you had a urinary tract, bladder, or kidney infections within the last year?	Do you have problems with control of urination?
Have you had any blood in your urine?	Any hot flashes or sweating at night?
Date of last pap and rectal exam?	Date of last Mammogram
Have you had any of the following infections? if yes circle your answer    Abnormal PAP    HPV    Herpes    HIV    Chlamydia    Gonorrhea	

## MEN ONLY

Do you usually get up to urinate during the night?	If yes, # of times _____
Do you feel pain or burning with urination?	Any blood in your urine?
Do you feel burning discharge from penis?	Has the force of your urination decreased?
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Do you have hesitancy in starting urination?
Have you had any of the following infections? if yes circle your answer    Herpes    HIV    Chlamydia    Gonorrhea    HPV	
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No

*See next page for additional information*

