

# Health History Questionnaire

Personal Health History							
Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio							
Immunizations & Year:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> MMR (measles, mumps, rubella)			
	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Influenza	<input type="checkbox"/> Hepatitis B				
Previous or referring Doctor:			Date of last physical:				
Please list any other medical diagnoses:							
Surgeries/hospitalizations (not including pregnancies):							
Year	Reason			Hospital			
<b>Exercise</b>	<input type="checkbox"/> Sedentary (no exercise)		<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	<input type="checkbox"/> Mild exercise		<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.)				
<b>Diet</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				
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Soda	# of cups/cans per day:		
<b>Alcohol</b>	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what kind?	# drinks per week:	# of years drinking:		
<b>Tobacco</b>	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No		# of years/or year quit:	<b>Circle all that apply:</b> Cigarettes/Pipe/Cigars/Chew #pks/day or frequency:			
Medical History							
Please check all that apply							
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Anemia		
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Cough	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Gout		
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Leg blood clots	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Ulcers		
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Cancer		
<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Chest Tightness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Thyroid		
<input type="checkbox"/> Lung problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Constipation	<input type="checkbox"/> Nausea & vomiting	<input type="checkbox"/> HIV/AIDS		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Fainting/dizziness	<input type="checkbox"/> Bloody/tarry stool	<input type="checkbox"/> Kidney/bladder prob	<input type="checkbox"/> STD history		
<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Accident (auto/fall)	<input type="checkbox"/> Headaches	<input type="checkbox"/> Weight change	<input type="checkbox"/> Back pain	<input type="checkbox"/> Foot pain		
<input type="checkbox"/> Hayfever/allergies	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Energy level change	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Shoulder pain		
<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Seizures	<input type="checkbox"/> Depression	<input type="checkbox"/> Change in ability to sleep				
Women Only							
Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, are you trying for a pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If not trying for a pregnancy list contraceptive or barrier method used:							
Are you pregnant or breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No		# of pregnancies ___ live births ___ miscarriages ___ abortions ___					
Age of onset menstruation:		Date of last menstruation:		Period every ___ days			
Heavy periods, irregularity, spotting, pain or discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No			Any hot flashes or sweating at night? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Date of last pap exam?		Date of last Mammogram?					
Family Medical History							
Age		Significant Health Problems		Age		Significant Health Problems	
Father			Children				
Mother							
Grandmother			Siblings				
Grandfather							