HEALTH HISTORY QUESTIONARE

Name (Last, First ,MI) □ M □ F	DOB
Previous/Referring Doctor	Reason for Today's Visit

List your prescribed drugs and over-the-counter drugs such as vitamins and inhalers

Name of the Drug	Strength of Medication	Frequency taken

List any medical problems that other doctors have diagnosed

Allergies to medications

Name of the Drug	Severity	Reaction you had
	□ Mild □ Moderate □ Severe	
	□ Mild □ Moderate □ Severe	
	□ Mild □ Moderate □ Severe	
	□ Mild □ Moderate □ Severe	

Surgeries

Year	Type of Surgery and Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children	□ M □ F	
Mother				□ M □ F	
Sibling	□ M □ F			□ M □ F	
	□ M □ F			□ M □ F	
	□ M □ F		Grandfather Paternal		
	□ M □ F		Grandmother Paternal		
	□ M □ F		Grandfather Maternal		
	□ M □ F		Grandmother Maternal		

HEALTH HABITS AND PERSONAL SAFETY

Marital Status: □ Single □ Married □ Partnered □ Divorced □ Widowed

Alcohol	Do you drink alcohol? □ Yes □ No	**Tobacco**	Do you use tobacco? □ Yes □ No	
	If yes, what kind?		□ Cigarettes pks/day	□ Chew #/day
	How many drinks per week?		□ Cigars #/day	□ Pipe #/day
			□ # of years	□ year quit
Drugs	Do you currently use recreational or street drugs? □ Yes □ No			
	Have you ever given yourself street drugs with a needle? □ Yes □ No			

WOMEN ONLY

Are you pregnant or breastfeeding? □ Yes □ No	Number of Pregnancies	Number of live births

SYMPTOMS EXPERIENCED IN THE PAST 6 MONTHS (CHECK ALL THAT APPLY)

Neurological
- □ Headache
- □ Double Vision
- □ Slurred Speech
- □ Imbalance/Unsteady gait
- □ Falls
- □ Abnormal movements
- □ Tremor
- □ Memory loss
- □ Numbness/Tingling
- □ weakness
- □ Seizure
- □ Cramps/Spasms

General
- □ Fevers
- □ Chills
- □ Night sweats
- □ Excessive fatigue
- □ Weight gain/loss
- □ Trouble sleeping
- □ Trouble staying asleep
- □ vivid dreams

Throat/Sinus
- □ Nasal congestion
- □ Sinus pain
- □ Nose bleeds

Eyes/Ears
- □ Visual loss
- □ Blurred vision
- □ Eye pain
- □ Double vision
- □ Hearing loss
- □ Ringing in ears

Psychiatric
- □ Depression
- □ Anxiety
- □ High levels of stress
- □ Hallucinations
- □ Uncontrollable laughter/crying

Cardiac
- □ Chest pain
- □ Palpitation
- □ Syncope/Passing out
- □ Heart murmur

Urinary
- □ Frequency
- □ Incontinence
- □ Urgency
- □ Incomplete bladder emptying

Neck
- □ Neck stiffness
- □ Swollen lymph nodes

Vascular
- □ Swollen leg(s)
- □ Easy bruising or bleeding
- □ Recent Transfusions

GI
- □ Swallowing difficulty
- □ Constipation
- □ Diarrhea

Pulmonary
- □ Shortness of breath
- □ Dry cough
- □ productive cough

Musculoskeletal
- □ Joint pain
- □ Muscle aches