COMPLETE PHYSICAL EXAM VISIT - HEALTH HISTORY QUESTIONNAIRE

NAME: _____ AGE: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

ADDRESS: _____

TELEPHONE; HOME: _____ MOBILE: _____ WORK: _____

EMAIL ADDRESS: _____
(To receive health and practice information)

PAST MEDICAL HISTORY:

HAVE YOU:	NO / YES	IF YES PLEASE LIST
Any serious illnesses?	N Y	Please list _____
Ever been hospitalized?	N Y	For What? _____
Had any surgeries?	N Y	Please list _____

Cancer	NO	YES	Heart Disease	NO	YES
Pneumonia	NO	YES	Stroke	NO	YES
Tuberculosis	NO	YES	Diabetes	NO	YES
Chicken Pox	NO	YES	Hepatitis	NO	YES
High Blood Pressure	NO	YES	High Cholesterol	NO	YES
Sexually transmitted diseases	NO	YES	Blood Clots	NO	YES
			Does a partner, or anyone at home, hurt, hit or threaten you	NO	YES

MEDICATION: (INCLUDE HERBS AND VITIMINS) HOW OFTEN TAKEN:

_____

_____

_____

ALLERGIES:
Do you have any drug allergies? NO YES If yes, to what? _____

What symptoms did you have? _____

FAMILY HISTORY: (IF LIVING) (IF DECEASED)

AGE-HEALTH STATUS AGE AT DEATH – CAUSE OF DEATH

FATHER: _____

MOTHER: _____

BROTHER(S) _____

_____

_____

SISTER(S) _____

_____

_____

CHILDREN _____

HAS ANY BLOOD RELATIVES HAD?			WHICH RELATIVE?	HAS ANY BLOOD RELATIVES HAD?			WHICH RELATIVE?
Cancer	NO	YES	_____	Gout or Arthritis	NO	YES	_____
Diabetes	NO	YES	_____	Glaucoma	NO	YES	_____
Heart Disease	NO	YES	_____	Asthma or Hives	NO	YES	_____
Stroke	NO	YES	_____	High blood pressure	NO	YES	_____
Bleeding Problems	NO	YES	_____				

IMMUNIZATIONS: Have you had the basic immunization series of :

Tetanus and Diphtheria	NO	YES	Measles, Mumps and Rubella (MMR)	NO	YES
Polio	NO	YES	Pneumonia Vaccine	NO	YES
Hepatitis A	NO	YES	When was your last tetanus shot? _____		
Hepatitis B	NO	YES	Gardasil	NO	YES
			Zostovax	NO	YES
			Meningococal	NO	YES

SOCIAL HISTORY

ARE YOU: Single Married Divorced Separated Widowed (PLEASE CIRCLE)

Are you living with our husband, wife, or partner?	NO	YES	
Is your sex life satisfactory?	NO	YES	
Do you have dependents at home ?	NO	YES	
Do you drink alcoholic beverages?	NO	YES	How much per day/week? _____
Has anyone told you that you drink too much?	NO	YES	
Do you now smoke?	NO	YES	How many? _____ How Long? _____
Do you drink coffee, cola or tea?	NO	YES	How many cups? _____
Do you exercise?	NO	YES	How many times per week? _____
Have you used illicit drugs?	NO	YES	Which drugs and when? _____
Have you ever been tested for HIV?	NO	YES	Would you like to be? _____

What is / was your occupation? _____

Highest education obtained: _____

Describe job stress: (High) (Medium) (Low) Describe: _____

Do you wear seat belts? NO YES

SCREENING TESTS: (IF APPLICABLE)

Have you ever had a:

Mammogram?	NO	YES	When was it last done? _____
Bone Density Test?	NO	YES	When was it last done? _____
Chest X-Ray?	NO	YES	When was it last done? _____
EKG?	NO	YES	When was it last done? _____
Exercise Stress Test?	NO	YES	When was it last done? _____
Colonoscopy?	NO	YES	When was it last done? _____

SYSTEMS REVIEW: Do you have any of the following:

GENERAL:

Unexplained weight loss?	NO	YES
Chronic fevers?	NO	YES
Loss of appetite?	NO	YES

SKIN:

Skin disease?	NO	YES
Jaundice	NO	YES
Hives or Eczema?	NO	YES
Frequent infections or boils?	NO	YES
Abnormal moles?	NO	YES

HEAD-EYES-EARS-NOSE-THROAT

Eye disease?	NO	YES
Do you wear glasses?	NO	YES
Blurred vision?	NO	YES

NECK:

Stiffness?	NO	YES
Neck injury?	NO	YES
Enlarged neck glands?	NO	YES

RESPIRATORY:

Coughing / Spitting blood?	NO	YES
Chronic cough?	NO	YES
Asthma or wheezing?	NO	YES
Shortness of breath?	NO	YES
Difficulty walking 2 blocks?	NO	Yes
Night sweats?	NO	YES
Skin tested for tuberculosis?	NO	YES

CARDIOVASCULAR:

Chest pain or angina?	NO	YES

Glaucoma?	NO	YES
Frequent headaches?	NO	YES
Itchy eyes, runny nose, sneezing?	NO	YES
Frequent nosebleeds?	NO	YES
Chronic ringing in ear?	NO	YES
Sinus trouble?	NO	YES
Hearing loss or disease?	NO	YES
Dizziness or fainting spells?	NO	YES

GASTROINTESTINAL:

Stomach or duodenal ulcer?	NO	YES
Heartburn or indigestion?	NO	YES
Sour taste in throat or mouth?	NO	YES
Use antacids or Tums often?	NO	YES
Intolerance to spicy foods	NO	YES
Coffee or alcohol?	NO	YES
Vomiting up blood?	NO	YES
Gallbladder trouble?	NO	YES
Intolerance to greasy food?	NO	YES
Liver trouble?	NO	YES
Cramping, abdominal pain?	NO	YES
Chronic constipation?	NO	YES
Frequent diarrhea?	NO	YES
Uses laxatives often?	NO	YES
Recent change in bowel habits?	NO	YES
Bloody or black stools?	NO	YES
Hemorrhoids or piles?	NO	YES

GENITOURINARY

Leak urine when cough or sneeze?	NO	YES
Frequent bladder/kidney infections?	NO	YES
Burning or painful ruination?	NO	YES
Nighttime urination?	NO	YES
Feeling that you must		
Urinate immediately?	NO	YES
Bloody, pink or brown urine?	NO	YES
Kidney stones?	NO	YES

FOR MEN ONLY:

Difficulty starting urination?	NO	YES
Decrease in strength of urine stream	NO	YES
Discharge from penis?	NO	YES
Difficulty starting/maintaining erections?	NO	YES
Prostate Problems?	NO	YES

FOR WOMEN ONLY:

Age when period started _____ years old
Frequency of periods: Every _____ days
Length of each period _____
Number of pregnancies? _____
Number of deliveries? _____
Date of last Pap Smear? _____

Abnormal discharge or odor?	NO	YES
Extremely painful periods?	NO	YES
Painful intercourse?	NO	YES
Breast lumps or pain?	NO	YES

Heart trouble?	NO	YES
Heart attack or Heart disease?	NO	YES
Shortness of breath?	NO	YES
When laying down?	NO	YES
Wake up short of breath?	NO	YES
Heart murmurs?	NO	YES
Rapid or skipped heartbeats?	NO	YES
Swelling of hands, feet or ankles?	NO	YES

MUSCULOSKELETAL

Significant arthritis?	NO	YES
Weakness in leg or arm?	NO	YES
Difficulty walking?	NO	YES
Pain in calves or buttock on walking	NO	YES
Painful varicose veins?	NO	YES

NEUROLOGICAL:

Stroke?	NO	YES
Seizures?	NO	YES
Paralysis?	NO	YES
Numbness or tingling?	NO	YES
Loss of consciousness?	NO	YES

EMOTIONAL:

Do you sleep well?	NO	YES
Are you usually tired?	NO	YES
Are you often depressed?	NO	YES
Are you often anxious?	NO	YES
Do you feel hopeless or helpless?	NO	YES
Do you wish you were dead?	NO	YES
Do you worry often?	NO	YES
Do you have interest in friends or fun?	NO	YES
Have you ever been advised to see		
a psychiatrist?	NO	YES

HEMATOLOGICAL:

Anemia?	NO	YES
Unexplained bruising?	NO	YES
Excessive bleeding?	NO	YES

ENDOCRINE (Hormone):

Hormone therapy?	NO	YES
Thyroid disease?	NO	YES
Intolerance to mildly warm or mildly		
Temperatures?	NO	YES
Change in texture of hair or skin?	NO	YES
Change in voice?	NO	YES
Crave large amounts of fluids?	NO	YES
Significant change in shoe size	NO	YES
Severe fatigue?	NO	YES

Height _____ Ideal Weight _____

Signature: _____