

**Patient Health History Questionnaire**

Name (Last, First, M.I.) \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone (h): \_\_\_\_\_ (w): \_\_\_\_\_ (cell): \_\_\_\_\_

Primary medical doctor: \_\_\_\_\_

Were you referred by your primary doctor? Y / N

If not, how did you hear about us? Other M.D. / Family / Friend / Phonebook

What is the primary reason you are here today? \_\_\_\_\_

**Health History**

Please list any operations/ surgeries with approximate dates:

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Please list medications you are currently taking with dosages:

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Do you have any allergies to medications? Y / N If answer is YES, please list and describe what happened when you took that medicine.

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Please list any hospitalizations with cause, approximate dates:

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Please list any chronic medical conditions (e.g. High blood pressure, Diabetes etc.):

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Please list any family history of disease or illness, or health status of immediate family:

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Please check the following areas if you currently have any problems or related complaints:

<input type="checkbox"/> <b>General health</b> (fevers, weight loss, malaise)	<input type="checkbox"/> <b>Musculoskeletal</b> (arthritis, osteoporosis)
<input type="checkbox"/> <b>Cardiovascular</b> (heart attack, irregular heartbeat, chest pain)	<input type="checkbox"/> <b>Skin</b> (eczema, psoriasis, acne)
<input type="checkbox"/> <b>Respiratory</b> (asthma, emphysema, shortness of breath)	<input type="checkbox"/> <b>Neurologic</b> (stroke, seizures)
<input type="checkbox"/> <b>Gastrointestinal</b> (gastric reflux, ulcers, difficulty swallowing, abdominal pain, bleeding, liver disease)	<input type="checkbox"/> <b>Psychiatric</b> (depression, mania, schizophrenia)
<input type="checkbox"/> <b>Genitourinary</b> (prostate problems, incontinence)	<input type="checkbox"/> <b>Endocrine</b> (thyroid, diabetes)
<input type="checkbox"/> <b>Allergic/Immunologic</b> (immune deficiency, known environmental allergies)	<input type="checkbox"/> <b>Eyes</b> (glaucoma, cataracts, blurred vision)

Do you smoke? Y / N If yes, how much (i.e. packs/day) \_\_\_\_\_ and for how many years? \_\_\_\_\_

Do you regularly consume alcoholic beverages? Y / N If yes, how many drinks daily? \_\_\_\_\_

What is your current employment/ occupation? \_\_\_\_\_

What is your marital status? Single / Married / Divorced / Widowed

*Office use only. I have reviewed the above information with the patient.*

M.D.