

**PATIENT HEALTH HISTORY QUESTIONNAIRE**



The following information is very important to your plan of care.  
 Please take time to fully and completely fill out this important information.  
 We are counting on you. Please complete every section. Do not leave any blanks.

Appt. \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F  Right hand dominant  
 Left hand dominant

Marital status: Single Married Widowed Divorced Occupation: \_\_\_\_\_

Family Dr: \_\_\_\_\_ Requesting Dr: \_\_\_\_\_

Other treating physicians: \_\_\_\_\_

What will we be seeing you for? \_\_\_\_\_

**YOUR PAST MEDICAL HISTORY (6 months or longer ago)**

No significant past medical history

Do you have now, or have you ever had any of the following?

		No	Yes			No	Yes	
Abdominal aortic aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heartburn/Reflux/GERD	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis / Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Irregular Heart Rate	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Back Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Blood Clots/DVT	<input type="checkbox"/>	<input type="checkbox"/>	_____	Supplemental Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Cancer (Location)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Carotid artery disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Crohn's/Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____	MRSA	<input type="checkbox"/>	<input type="checkbox"/>	_____	
COPD	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Congestive heart failure (CHF)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pacemaker/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Diabetes - Type I	<input type="checkbox"/>	<input type="checkbox"/>	_____	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Diabetes - Type II	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychiatric Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pulmonary embolus	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatoid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Epilepsy / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Serious Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Heart Attack/MI	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	Vascular Disease/Stents	<input type="checkbox"/>	<input type="checkbox"/>	_____	
				Venereal Disease / STD	<input type="checkbox"/>	<input type="checkbox"/>	_____	
				Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	

Other: \_\_\_\_\_

IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING, PLEASE CIRCLE:

SHELLFISH IODINE X-RAY DYE EGGS POULTRY FEATHERS LATEX METAL NICKEL

If allergic, what was your reaction? \_\_\_\_\_

DRUG ALLERGIES or ADVERSE REACTIONS:  NO  YES – Please list: \_\_\_\_\_

LIST ALL MEDICATIONS AND SUPPLEMENTS. Please Include Dosage:  No Medications

Do you take any blood thinners?  NO  YES

PRESCRIPTION MEDICATIONS:

MEDICATION	DOSE	DIRECTIONS/SIG	REASON/INDICATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OVER THE COUNTER MEDICATIONS: \_\_\_\_\_

HERBALS, VITAMINS OR SUPPLEMENTS: \_\_\_\_\_

HOSPITALIZATIONS: <input type="checkbox"/> No <input type="checkbox"/> Yes—please explain	Year	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

SURGERY (TYPE): <input type="checkbox"/> No <input type="checkbox"/> Yes—please explain	Year	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

**SOCIAL HISTORY – Please mark every area**

YOUR PERSONAL HABITS: Do you...	YES	No	If YES, Please explain:
Smoke? / Use any tobacco products? If ever, when did you stop?	<input type="checkbox"/>	<input type="checkbox"/>	how much? _____
Use alcohol? Were you ever a heavy drinker?	<input type="checkbox"/>	<input type="checkbox"/>	how much? _____
Use illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____

**FAMILY HISTORY – Has anyone in your family had any of the following problems?**

No significant past family history

Unknown family history

Disease	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brothers/Sisters	Other Relative
High blood pressure/ Hypertension						
Heart Attack/ Heart surgery						
Diabetes						
Stroke						
Cancer (type)						
Osteoporosis						
Thyroid problems						
Problems with anesthesia						
Malignant hyperthermia						
Blood clots/Blood Diseases						
Other -						

**REVIEW OF SYSTEMS**

Have you been troubled with any of the following symptoms within the last 4 – 6 weeks?

**General**

Fever No Yes  
Sweats No Yes

**Genitourinary**

Urinary frequency No Yes  
Burning No Yes  
Blood in urine No Yes  
Difficulty urinating No Yes

**Neurologic**

Numbness/tingling No Yes  
Tingling No Yes  
Headaches No Yes  
Weakness No Yes

**Respiratory**

Cough No Yes  
Shortness of  
Breath No Yes  
Wheezing No Yes

**Skin**

Itching No Yes  
Rash No Yes  
Slow healing wounds No Yes

**Allergy**

Hives No Yes  
Seasonal symptoms No Yes  
Sneezing No Yes  
Nasal congestion No Yes

**Musculoskeletal**

Joint swelling No Yes  
Joint pain No Yes  
Muscle pain No Yes

**Cardiovascular**

Chest pain/pressure No Yes  
Ankle swelling No Yes  
Irregular heartbeat No Yes

**Hematologic**

Easy bruising No Yes  
Easy bleeding No Yes  
Hard to stop bleeding No Yes

**Eyes**

Blurred vision No Yes  
Changing vision No Yes  
Double vision No Yes  
Wear glasses/  
Contacts No Yes

**Gastrointestinal**

Nausea No Yes  
Vomiting No Yes  
Constipation No Yes  
Diarrhea No Yes  
Blood in stool No Yes

**Nutrition**

Special diet No Yes  
Weight loss/gain No Yes  
Change in appetite No Yes

**Mental Health**

Insomnia No Yes  
Anxiety No Yes  
Depression No Yes  
Suicidal thoughts No Yes  
Memory loss No Yes

**Endocrine**

Excessive urination No Yes  
Excessive thirst No Yes  
Fatigue No Yes  
Heat or cold intolerance No Yes

**Ear/Nose/Throat**

Ear pain No Yes  
Hearing loss No Yes  
Nose bleeds No Yes  
Sore throat No Yes

The above information is true and correct to the best of my belief.

\_\_\_\_\_  
Patient Signature (Parent or Guardian for Minor) / Date  
CLINICAL ASSISTANT/REVIEWER INITIALS: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature / Date