



History Questionnaire

Patient's Full Name: _____

Spouse or Responsible Party: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Date of Last Physical Exam: _____ Date of Last Pap Smear: _____

Personal History (Yes or No)

_____ Diabetes

_____ Tuberculosis

_____ Cancer

_____ Heart Disease

_____ High Blood Pressure

_____ Blood Disease

Other Diseases not mentioned _____

Operations, Injuries, and approximate dates: _____

Hospitalizations (X-rays & EKG's), other than for operations: _____

Diet Restrictions: _____ Yes _____ No

Smoke: _____ Yes _____ No

Living Will: _____ Yes _____ No

Marital Status: Single, Married, Divorced, Widowed Number of Children: _____

Immunizations: Last Tetanus _____ Influenza _____ Pneumovax _____

Work History: Toxin Exposure: _____ Yes _____ No

Retired: _____ Yes _____ No

Medical Disability: _____ Yes _____ No



History Questionnaire (continued)

Family History

If Living: Age and Medical Problems

If Deceased: Age at Death and Cause of Death

Father: _____

Mother: _____

Brother (s): _____

Sister (s): _____

Is there a family history of:

	Yes	No	Relationship
Diabetes			
Cancer			
Stroke			
Hypertension			
Arthritis			
Heart Disease			
Other			

List all the medications (Prescription and Over the Counter) you are currently taking. Include dose (mgm) and how many times a day your take each one.

Medication	Dose (mgm)	How Often?

Allergies:

Drugs: _____

Food: _____

Other: _____

History Questionnaire (continued)

STUDY OF SYSTEMS																
Check Yes or No for each item except where applies to male or female																
Condition			Yes	No	Condition			Yes	No	Condition			Yes	No		
Head	Fever			Neck	Stiffness			Psychological	Is Your Life:							
	Chills				Swelling				Satisfactory							
	Bruise Easily				Lumps				Boring							
	Swollen Glands				Other*				Demanding							
	Loss of Memory			Gastrointestinal	Appetite Poor				Unsatisfactory			Is There Worry Over:				
	Genreal Weakness				Indigestion/Heartburn				Home Life							
	Aches/Pains				Nausea				Marriage							
	Double Vision				Vomiting Blood				Job							
	Light Flashes				Abdominal Pain or Cramps				Children							
	Blurred Vision w/o Glasses				Abdominal Tension				Money							
	Halos Around Lights				Biarrhea				Do You:							
	Eye Pains				Constipation				Often feel Depressed							
	Ear Pains				Bowel Habit Changes				Have Irrational Fears							
	Ear Drainage				Rectum Blood Passage				Feel Upset							
Buzzing/Ringing in Ears			Black Tar-Type Bowel Movements			Feel Things Often Go Wrong										
Nosebleeds			Other*			Feel Shy										
Sinus Problems			Kidney	Up Nights to Urinate			Cry Easily									
Swallowing Problems				Blood in Urine			Feel Inferior									
Deafness				Burning or Pain While Urinating			Have You:									
Mouth, Tooth or Tongue Problems				Problems Passing Urine			Attempted Suicide									
Persistent Hoarseness				Trouble Controlling Urine			Seriously Considered Suicide									
Servre Headaches				Other*			Men Genitalia	Lump In Testicle								
Other*			Neu Musc	Leg or Arm Weakness				Penis Discharge								
Rash				Balance Problems				Breast Lump								
Changing Moles				Dizziness				Sore on Penis								
Pigmentation				Fainting Spells				Erection Difficulites								
Other Skin Problems*			Speech Problems			Other*										
Chest Heart Lungs	Irregular Heartbeat			Other*	Bone Joint	Joint Pains			Women Genitalia	Breast Lump						
	Shortness of Breath					Joint Swelling				Nipple Discharge						
	Low Exercise Tolerance					Muscle Strength Loss				Vaginal Discharge						
	Heart Flutters			Muscle Lump or Swelling				Non-Period Bleeding/Spoting								
	Chest Pains			Lump on Bone				Hot Flashes								
	Frequent Coughs			Pains in Back				Pain with Intercourse								
	Cough Up of Blood			Other*				Possibly Pregnant								
	Wheezing			Endocrine		Constant Thirst				Change in Periods						
	Night Sweats					Most Always Cold				Pain Other Than with Periods						
	Swollen Ankle					Too Warm Most Times				Other*						
	Cramps in Legs					Very Sluggist or Tired										
Other*			Jumpy / Nervous													
Explain Other*																
Doctor's Use Only - Summary																