HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Where information is filled in, please confirm it is correct.

NAME	SEX	BIRTHDATE/AGE	CONSULTATION DATE
	M ☐ F ☐		
ADDRESS		**Phone**	**Contact**

REFERRAL INFORMATION (please add all doctors that you would like us to be in contact with)

Referral Doctor:
Primary Care doctor:

Other doctors (and specialty):

How did you decide to see us? (check all): ☐My Referring Doctor ☐Another Doctor :
☐Friend or Neighbor ☐Heard Radio Ad ☐ Saw Print Ad (where:) ☐ Web Search
Have you visited our website? ☐ Y ☐ N Comments on site:

DIAGNOSIS or REASON FOR TODAY'S VISIT

WHEN DIAGNOSED, HOW DIAGNOSED, FIRST SYMPTOMS

WHAT OTHER MEDICAL PROBLEMS DO YOU HAVE/HAVE YOU HAD?

PROBLEM	YES	NO	Doctor treated? YES	Doctor treated? NO	Details (include approximate date of diagnosis, at least)
AIDS/HIV positive	☐	☐	☐	☐	
Alzheimer's	☐	☐	☐	☐	
Arthritis	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Back problems	☐	☐	☐	☐	
Blood transfusions	☐	☐	☐	☐	
Bone loss (osteoporosis)	☐	☐	☐	☐	
Crohn's disease or ulcerative colitis	☐	☐	☐	☐	
Cancer (other than current one)	☐	☐	☐	☐	

PROBLEM (cont.)	YES	NO	Doctor treated? YES	NO	Details (include approximate date of diagnosis, at least)
Cardiac disease or other heart	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Emphysema or lung problems	☐	☐	☐	☐	
Lupus or scleroderma	☐	☐	☐	☐	
Gallstones	☐	☐	☐	☐	
GERD (reflux, heartburn)	☐	☐	☐	☐	
Hepatitis	☐	☐	☐	☐	
High cholesterol	☐	☐	☐	☐	
High blood pressure	☐	☐	☐	☐	
Hypothyroid or hyperthyroid	☐	☐	☐	☐	
Impotence or infertility	☐	☐	☐	☐	
Kidney disorders or stones	☐	☐	☐	☐	
History of mononucleosis?	☐	☐	☐	☐	
Depression or mental illness	☐	☐	☐	☐	
Stroke or TIAs	☐	☐	☐	☐	

PRIOR ROUTINE TESTS:	YES	NO	
Do you receive regular mammograms?	☐	☐	Date of last mammogram:
Do you receive regular Pap smears?	☐	☐	Date of last Pap smear:
Do you have regular PSA checks?	☐	☐	Date of last PSA:
Do you have a pacemaker/debrillator?	☐	☐	Date of your last physical exam:

LIST ALL MAJOR SURGERIES (provide details, including approximate dates)

EXTENDED HOSPITALIZATIONS (stays in the hospital for more than 48 hours—provide details)

HAVE YOU EVER HAD RADIATION THERAPY TREATMENTS BEFORE?	YES ☐ NO ☐	IF YES, what part of your body, where given and dates:

OBSTETRIC HISTORY (females only)

Number of times pregnant: Number of children with which you've been pregnant:
Premature births: Abortions (spontaneous or other): Living children:

MEDICATION HISTORY:
list ALL medications you are now taking, including vitamins and over counter

Name of drug	Strength	Taking for what problem:

HORMONE THERAPY:

Are you receiving hormone therapy? No ☐ Yes ☐ Name of medication:
Date therapy started:

CHEMOTHERAPY HISTORY:

Have you received, or are you currently receiving, chemotherapy treatments? Yes ❑ No ❑

	Chemotherapy name	Number of cycles/cycle frequency	Date started	Date finished
1.				
2.				
3.				
4.				

Have you met with a chemotherapy doctor yet? No ☐ Yes ☐, Name of doctor:

Has he/she scheduled you to start chemotherapy? No ☐ Yes ☐, Date scheduled to start:

ALLERGIES: to MEDICATIONS or other?

☐ I am NOT allergic to any medications

☐ I am allergic to the following medications: (List medications & reaction that you get, i.e. rash, fainting, etc.)

1.
2.
3.

Have you ever had anesthesia?	No ☐	Yes ☐	, Explain:
Anyone in your family ever had problems with anesthesia?	No ☐	Yes ☐	, Explain:
Have you ever received intravenous contrast?	No ☐	Yes ☐	, Explain:
If you received IV contrast, did you have any problems?	No ☐	Yes ☐	, Explain:
Do you have any seafood allergies?	No ☐	Yes ☐	, Explain:
Do you have other allergies?	No ☐	Yes ☐	, Explain:

FAMILY HISTORY

MOTHER
☐ living ☐ deceased (at age: , cause)
Mother's CANCER history or major medical problems:

FATHER
☐ living ☐ deceased (at age: , cause)
Father's CANCER history or major medical problems:

OTHER FAMILY MEMBERS WITH HISTORY OF CANCER: list relationship and type of cancer

Smoking History

Do you currently smoke? ☐ Y ☐ N
How many years: About how many packs/day:

Have you ever smoked? ☐ Y ☐ N
When did you quit, if you used to smoke?
How many years did you smoke: About how many packs/day:

Alcohol, Caffeine or Drug Use History

Do you currently drink alcoholic beverages? ☐ Y ☐ N
What kind, how often, and how much: :

Have your current habits of alcohol use changed? ☐ Y ☐ N, Explain: :

Caffeine? (coffee, soft drinks, etc? ☐ Y ☐ N how much: :

Other drug use, at present or in past? ☐ Y ☐ N, Describe: :

Social History

Are you married? ☐ Y ☐ N, how long: : _____
Do you have any children?: ☐ Y ☐ N, ages: : _____

Are you currently working? ☐ Y ☐ N
What is your occupation (or what was it before you retired, were disabled, etc.)?: :
_____
How long have you/did you work at your job(s)?: : _____ years
Any chemical or other hazardous material exposure at work? ☐ Y ☐ N, Explain: :
Are you currently on disability at your job? ☐ Y ☐ N

SYSTEM-SPECIFIC QUESTIONS

(Circle 'Yes' or 'No'. If 'Yes', please explain)

GENERAL		
Weight loss	☐No	☐Yes
Weight gain	☐No	☐Yes
Fever	☐No	☐Yes
Chills	☐No	☐Yes
Night sweats	☐No	☐Yes
Fatigue	☐No	☐Yes

EYES		
Use glasses or contacts?	☐No	☐Yes
Painful, itchy, or red eyes	☐No	☐Yes
Blurry vision	☐No	☐Yes
Double vision	☐No	☐Yes
Spots, specks, flashing lights	☐No	☐Yes
Excess tearing	☐No	☐Yes
Very dry eyes	☐No	☐Yes

EARS, NOSE, MOUTH, THROAT			
Use hearing aids	☐No	☐Yes	
Changes in hearing	☐No	☐Yes	
Pain in ears	☐No	☐Yes	
Ringing in ears	☐No	☐Yes	
Discharge from ears	☐No	☐Yes	_
Nasal bleeding/discharge	☐No	☐Yes	
Stuffy nose	☐No	☐Yes	_
Changes in smell	☐No	☐Yes	
Changes in taste	☐No	☐Yes	_
Use dentures?	☐No	☐Yes	
Hoarseness	☐No	☐Yes	
Spitting up blood	☐No	☐Yes	
Pain in mouth or throat	☐No	☐Yes	
Difficulty moving tongue	☐No	☐Yes	
Difficulty swallowing	☐No	☐Yes	

SKIN		
Rashes	☐No	☐Yes
Swelling	☐No	☐Yes
Sores	☐No	☐Yes
Itching	☐No	☐Yes
Dryness	☐No	☐Yes
Color changes/yellowing	☐No	☐Yes
Changes in hair or nails	☐No	☐Yes

FEMALES: BREAST		
Lumps	☐No	☐Yes
Soreness	☐No	☐Yes
Clear nipple discharge	☐No	☐Yes
Bloody nipple discharge	☐No	☐Yes
Perform regular self-exams	☐No	☐Yes

RESPIRATORY		
Cough	☐No	☐Yes
Excess sputum production	☐No	☐Yes
Coughing up blood	☐No	☐Yes
Shortness of breath	☐No	☐Yes
History of pneumonia	☐No	☐Yes
History of tuberculosis	☐No	☐Yes

CARDIAC		
Heart palpitations	☐No	☐Yes
Heart murmurs	☐No	☐Yes
Heart attacks	☐No	☐Yes
Chest pain	☐No	☐Yes
Pacemaker	☐No	☐Yes

GASTROINTESTINAL		
Heartburn	☐No	☐Yes
Nausea	☐No	☐Yes
Vomiting	☐No	☐Yes
Indigestion	☐No	☐Yes
Changes in stool color	☐No	☐Yes
Changes in stool size	☐No	☐Yes
Blood in stool	☐No	☐Yes
Constipation	☐No	☐Yes
Diverticulosis/Diverticulitis	☐No	☐Yes
Diarrhea	☐No	☐Yes

SYSTEM-SPECIFIC QUESTIONS (cont.)

(Circle 'Yes' or 'No'. If 'Yes', please explain)

FEMALES: GENITAL		
How old at first period?	Age:_____	
Regular periods	☐No	☐Yes
Pain with intercourse	☐No	☐Yes
Very painful periods	☐No	☐Yes
Birth control pill use	☐No	☐Yes
How old at menopause?	Age:_____	
Decreased libido	☐No	☐Yes
Vaginal discharge	☐No	☐Yes
Hormone replacement use	☐No	☐Yes
Complications w/ pregnancies	☐No	☐Yes

MALES: GENITAL		
Hernias	☐No	☐Yes
Discharge from penis	☐No	☐Yes
Testicular pains	☐No	☐Yes
Testicular masses	☐No	☐Yes
Decreased libido	☐No	☐Yes

ENDOCRINE		
Thyroid dysfunction	☐No	☐Yes
Hot/cold intolerance	☐No	☐Yes
Excessive sweating	☐No	☐Yes
Excessive thirst	☐No	☐Yes
Excessive hunger	☐No	☐Yes

PSYCHIATRIC		
Nervousness	☐No	☐Yes
Depression	☐No	☐Yes
Mood swings	☐No	☐Yes
Feelings of hopelessness	☐No	☐Yes

VASCULAR		
Poor circulation	☐No	☐Yes
Leg cramps	☐No	☐Yes
Varicose veins	☐No	☐Yes
Clots in veins	☐No	☐Yes

MUSCULOSKELETAL		
Muscle or joint pains	☐No	☐Yes
Stiffness	☐No	☐Yes
Arthritis	☐No	☐Yes
Gout	☐No	☐Yes
Backache	☐No	☐Yes
Swollen extremities	☐No	☐Yes
Decreased motion arms/legs	☐No	☐Yes

NEUROLOGIC		
Fainting spells	☐No	☐Yes
Blackouts	☐No	☐Yes
Numbness	☐No	☐Yes
Weakness	☐No	☐Yes
Paralysis	☐No	☐Yes
Coordination problems	☐No	☐Yes
Migraines	☐No	☐Yes
Tremors	☐No	☐Yes
Involuntary movements	☐No	☐Yes

URINARY		
Pain or burning with urination	☐No	☐Yes
Blood in urine	☐No	☐Yes
Incontinence	☐No	☐Yes
Kidney Stones	☐No	☐Yes
Other:		

CERTIFICATION

I attest that all of the information in this document is true and correct to the best of my knowledge and understand my physician will base his opinions and judgments on the same.

Type Your Name to Certify: Todays Date: