Center for Integrated Health Care, PC

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Health History Questionnaire

Name:_____ Date:_____
Last First Middle

I. Past Medical and Surgical History:

A. Past Surgeries (including broken bones, accidents – list by age and date)

_____
_____

B. Illnesses (including hospitalizations):

_____
_____

C. Current Medications (Please list name, dosage & times per day):

1._____ 2._____
3._____ 4._____
5._____ 6._____

D. Do you have any of the following medical conditions?
____Diabetes ____High Blood Pressure ____Asthma ____Heart Disease
____Thyroid

E. Allergies (includes sensitivities and intolerance to medications, beestings, pollens):

_____

F. Immunizations:
Year of last tetanus_____ Flu Shot_____ Pneumonia Shot_____
Hepatitis B_____ Other_____

II. Social History

A. ____Married ____Single ____Widowed ____Divorced ____Separated

B. Children (How many? And years of birth:)

C. Education (# of years, degree)

D. Employment (company. position, year began and current job):

E. Cigarette use (number of cigarettes per day and year began smoking):

F. Alcohol use (number of drinks and how many times per week): _____

III. Family History:

Please answer the following about your family medical history (please note history of hypertension diabetes, heart disease, cancer (type), mental illness, alcoholism, thyroid):

	Living	Deceased	Age	Diseases
Mother:				
Father:				
Children:				
Granparents:				
Siblings:				

IV. Review of Systems (check all that apply):

A. General

____fatigue ____weakness ____daytime sleepiness
____Fever ____night sweats ____sleep difficulties
____weight loss/gain; If yes, # of pounds____in # of months____

B. Skin

____rash ____itching ____new moles
____easy bruising ____dry skin

C. Eyes

____glasses/contacts ____blindness ____double vision
____Glaucoma ____cataract/surgery ____itchy eyes

D. Ears, Nose, Throat, Sinus

____nasal congestion ____sinus pain ____post nasal drip
____allergies If yes, ____seasonal ____environmental

____hearing loss ____Hearing aids ____sore throat
____snoring ____trouble swallowing ____ painful swallowing
____dentures ____hoarse voice

E. Lungs

____asthma ____morning cough ____wheezing
____chest tightness ____sputum production ____pauses in breathing
____shortness of breath ____if yes, ____going upstairs ____at rest
____lying down ____waking at night

F. Heart

____chest pain ____chest pressure/fullness
____heart murmur ____heart palpitations ____racing heart beats

G. Stomach and intestines

____heart burn ____ulcers ____gas/bloating
____nausea ____vomiting ____abnormal pain
____constipation ____diarrhea ____frequent use antacids

H. Joints

____arthritis ____gout ____neck pain ____back pain
do you use a ____walker, ____cane, ____wheelchair
have you used in the past: ____physical therapy ____chiropractor
____massage therapy

I. Breast

____pain: If yes, ____cyclic ____lumps ____fibrocystic changes
____nipple discharge

J. Neurological

____headaches: If yes, types_____ location_____

frequency_____

____seizure ____head injury ____tremor ____black-outs
____fainting ____memory loss ____paralysis ____lightheaded

K. Rectal

____rectal pain ____rectal bleeding ____black stools ____rectal rash
____hemorrhoids ____problems holding stool

L. Urinary

____burning ____blood in urine ____kidney stones
____frequency: If yes, # times/per day_____ # per night_____
____infections: If yes, ____bladder ____kidney ____prostate
____problems holding urine ____problems starting urine

M. Gynecologic (female only)

____vaginal discharge ____vaginal itching ____vaginal bleeding
____sexual problems ____hysterectomy ____severe menstrual cramps
____heavy menstrual bleeding ____ Irregular periods ____pain during intercourse

N. Male Information

____penile discharge ____testicular lumps/swelling/pain
____erectile dysfunction

O. Mental Health

____nervousness, anxiety ____jumpiness ____sweating
____irritability/agitation ____restlessness ____fatigue
____sad/down/depressed ____increase/decrease appetite
____frequent crying/weeping ____worthless feelings
____decrease in sex drive ____sleeping problems
____thoughts of death/suicide ____hopeless feelings
____fearful feelings ____constant worry
____Fear of dying