CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Name: _____ DOB:_____ Age:_____ Date:_____

PAST MEDICAL HISTORY: List any chronic/severe or recurrent illnesses

Date: Nature of problem:

_____
_____
_____
_____
_____

LIST ANY HOSPITALIZATIONS/ SURGERIES

Date: Operation/hospitalization Reason

_____
_____
_____
_____
_____

LIST ALL MEDICATIONS: prescription & non-prescription which you take regularly

Medication: Dose: Frequency of use:

_____
_____
_____
_____
_____

ALLERGIES- List any medications and substances to which you are allergic

Substance: Reaction:

_____
_____
_____
_____
_____

READ THE FOLLOWING LIST AND CHECK ANY THAT YOU HAVE HAD:

___ Vision Impairment
___ Hearing Impairment
___ Anemia
___ Cancer
___ Bleeding Disorder
___ Sickle Cell Disease
___ Blood Clots
___ High Blood Pressure
___ Heart Disease
___ Rheumatic Fever
___ Elevated Cholesterol
___ Stroke
___ Muscle Disease or Weakness
___ Seizures
___ Severe Headaches
___ Concussion or Head Injury
___ Chronic Back Pain
___ Broken or Cracked Bones
___ Severe Sprains or Dislocation
___ Severe Lacerations
___ Bone or Joint Disease
___ Arthritis or Gout
___ Ulcer Disease
___ Chronic Bowl/ Colon Disease
___ Pancreatitis
___ Gallbladder Disease
___ Hepatitis and/or Cirrhosis
___ Tuberculosis
___ Asthma
___ Recurrent Pneumonia
___ Recurrent Bronchitis
___ Bladder or Kidney Infections
___ Kidney Disease or Stones
___ Gonorrhea or Syphilis
___ Herpes/ Chlamydia
___ DES exposure

IMMUNIZATIONS/ WELL CARE:

Have you had:		
Cholesterol Test	Yes___ No ___	Date:_____
Pap Smear	Yes___ No ___	Date:_____
Mammogram	Yes___ No ___	Date:_____
Sigmoidoscopy	Yes___ No ___	Date:_____
Pneumonia/Influenza Shot	Yes___ No ___	Date:_____
Tetanus Shot	Yes___ No ___	Date:_____
Measles & Mumps Shots	Yes___ No ___	Date:_____
Rubella Shot or Blood Test	Yes___ No ___	Date:_____
Diphtheria Shot	Yes___ No ___	Date:_____
Hemophilus Influenzae Vaccine (HIB)	Yes___ No ___	Date:_____
TB Skin Test (pos neg)	Yes___ No ___	Date:_____
Hepatitis Shots	Yes___ No ___	Date:_____
Polio Vaccine	Yes___ No ___	Date:_____

PERSONAL HISTORY

MARITAL HISTORY:

My current status is: Married Single Widowed Divorced

With whom do you now live? _____
_____

RELIGION:

Religious preference: _____
_____

HAVE YOU BEEN IN THE MILITARY? Yes No

EDUCATION & OCCUPATION:

Highest education achieved:
_____
_____

Present position/employment:
_____
_____

Previous jobs?
_____
_____ _____

Exposure to toxins at work? No Yes – Type:
_____

REVIEW OF SYSTEMS/ PERSONAL HISTORY

FAMILY HISTORY

	If living	If deceased
	Age/ Health	**Cause/ Age at death**
Father		
Mother		
Brother/Sister		
Husband/Wife		
Son/Daughter		
Grandmother		
Grandfather		
Grandmother		
Grandfather		
Other diseases that run in your family:		

Please check any conditions had by a blood relative:

(x)	Condition	Who
	Sickle Cell	
	Bleeding Disorder	
	Cancer (state type)	
	Heart Disease	
	High Blood Pressure	
	Stroke	
	Epilepsy	
	Alcoholism	
	Suicide	
	Allergies	
	Asthma	
	Arthritis	
	Gout	
	Diabetes	
	Thyroid Disease	
	Kidney	
	Tuberculosis	

SEXUAL AND REPRODUCTIVE HEALTH

MENSTRUATION:
Age periods began: _____
Cycle length: _____
Period length: _____
Last menstrual period:_____

FLOW:
Heavy Medium Light

DISCOMFORT:
Severe Moderate Mild

PMS (Pre-Menstrual Syndrome):
Yes No

PREGNANCIES:
Total number: _____
Full Term: _____
Premature: _____
Stillbirths: ___ Miscarriages: ____
Abortions: _____
Tubal Pregnancy: _____

PREGNANCY COMPLICATIONS: _____
_____
_____

QUESTIONS FOR BOTH MEN & WOMEN:
What kind(s) of birth control do you and/or your partner use?
_____
Have you had concerns about fertility? What type of concerns?
_____
How would you describe your sexual orientation?
_____
Do you have any questions/ problems regarding your sex life?
_____

QUESTIONS FOR MEN ONLY:
Have you had problems with:
Prostate? Impotence?
Lump on testis?

HABITS

DIET & EXERCISE:
Do you follow a special diet?
Weight: Current: ____
Desired: ____ 1 year ago:_____
Exercise: What kind of exercise do you do?_____
_____
_____

TOBACCO USE:

How much do you smoke? None
Regularly- _____/per day
Have you quit smoking? No
Yes- When? _____
Do you use any other tobacco?
No Yes- What? _____

ALCOHOL USE:

Do you drink alcohol No Yes
Have you had problems with your drinking? No Yes
If Yes, please explain:_____
_____
_____
What is your usual drinking pattern? _____
_____