HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*: ☐ **Male** ☐ **Female**	**DOB**:

MEDICAL HISTORY	
Diagnosis:	**Date of Diagnosis:**

Have you ever been diagnosed with any of the following medical problems?	**Date**	**List any Treatment**
☐ Brain Metastasis		
☐ Cardiac Issues *(please specify)*		
☐ Cirrhosis/Liver problems		
☐ Diabetes		
☐ Diverticulitis		
☐ Gastroesophageal reflux disease (GERD)		
☐ Hepatitis *(please specify)*		
☐ Hypertension (High blood pressure)		
☐ Lung Disease		
☐ Peripheral Neuropathy		
☐ Pulmonary Embolism/Deep Vein Thrombosis		
☐ Renal Disease		
If you have other medical problems please list below:	**Date**	**List any Treatment**

PROCEDURE/SURGICAL HISTORY	
List any Surgeries/Procedures	**Date**

CHEMOTHERAPY/CANCER TREATMENT	
List any Chemotherapies or Cancer Treatments	**Date**

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Have you ever had a blood Transfusion?	☐ **Yes**	☐ **NO**

ALLERGIES	
☐ **No Known Allergies**	
Drug/Food/Bees/Other ***(please specify)***	**Reaction**

WOMEN			
Pregnancies	Total number of pregnancies: _____		
	Number of live births: _____		
	Age at first birth: _____		
	Number of interrupted pregnancies (miscarriage/abortion): _____		
Menstruation	Age of first menstrual period: _____		
	Last menstrual period start date: ____/____/____		
	Menstrual cycle length (days): _____		
Menopause	☐ Pre-menopausal ☐ Peri-menopausal	☐ Post-menopausal	☐ Unknown
	Age at menopause: _____		
Menopause caused by:	☐ Natural ☐ Removal of ovaries ☐ Removal of uterus	☐ Surgical ☐ Total Hysterectomy	☐ Other *(please specify)*
Hormone Use	Have you used birth control pills? ☐ Yes ☐ No		# of years used:_____
	Have you used postmenopausal hormones? ☐ Yes ☐ No		# of years used:_____
	Have you used other kinds of hormones? ☐ Yes ☐ No		# of years used: _____
Last Pap Smear: Date: ____/____/____			☐ unknown
Last Mammogram: Date: ____/____/____			☐ unknown

MEN		
Date of last prostate and rectal exam:____/____/____		
Do you get up at night to urinate?	☐ Yes	☐ No
If yes, number of times:_____		
Do you have pain or burning while urinating?	☐ Yes	☐ No
Do you have blood in your urine?	☐ Yes	☐ No
Do you have a burning discharge from your penis?	☐ Yes	☐ No
Has the force of urine while urinating decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the past 12 months?	☐ Yes	☐ No
Do you have problems emptying your bladder completely?	☐ Yes	☐ No
Do you have difficulty with erection or ejaculation?	☐ Yes	☐ No
Do you have testicle pain or swelling?	☐ Yes	☐ No

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Name *(Last, First, M.I.)*:

SOCIAL HISTORY			
Support System:	☐ I have family/friends willing to assist me ☐ no support system exists		
Lives:	☐ with spouse ☐ significant other ☐ family ☐ friends ☐ alone		
Lives in:	☐ own house ☐ nursing home ☐ assisted living ☐ other		
Transportation:	☐ I have transportation (adequate) ☐ I don't have transportation and need assistance		
Activity	☐ Sedentary *(In bed/chair more than 1/2 day)*	☐ Light Exercise	
	☐ Daily activities	☐ Regular Exercise	
	☐ Occasional Exercise	☐ Extensive Exercise	
Nutrition	☐ Regular Meals	☐ Nutritional Supplements	☐ Liquid Diet
	☐ Vegetarian	☐ Diabetic Diet	☐ Cardiac Diet
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola # of cups/cans per day		
Smoking History	☐ Yes – current every day smoker ☐ Yes – current ***some*** day smoker ☐ Yes – but quit (former smoker) ☐ Never ☐ Heavy tobacco smoker ☐ Light tobacco smoker	Smoking # Years _____ Packs per Day _____ Years quit _____	
Alcohol History	☐ Yes – current every day drinker ☐ Yes – current ***some*** day drinker ☐ Yes – active ☐ Yes – but quit ☐ Never	Drinking # Days/Week _____ # Drinks/Day _____ Years quit _____	
Hazardous Materials Exposure:	Have you had exposure to hazardous materials? ☐ Yes – Contact ☐ No – No Contact	I have been exposed to: ☐ Asbestos ☐ Benzene ☐ Lead ☐ Radiation ☐ Other Petroleum Products ☐ Other *(please specify)*	
Products:	☐ Cigarettes ☐ Cigars ☐ Chewing tobacco ☐ Pipe	☐ Snuff ☐ Secondhand Smoke ☐ Recreational Drug Use ☐ Illicit Drug Use	☐ Marijuana ☐ Narcotics ☐ Electronic cigarettes
Sex	Are you sexually active?	☐ **Yes**	☐ **No**
	Do you have any discomfort with intercourse?	☐ **Yes**	☐ **No**
	Are you trying for a pregnancy?	☐ **Yes**	☐ **No**
	If not trying for a pregnancy please list contraceptive or barrier method used:		

HEALTH HISTORY QUESTIONNAIRE

Name *(Last, First, M.I.)*:

FAMILY HEALTH HISTORY

Parents	Living/Dead/Unknown	Age	Medical Problems	Age at Diagnosis
Mother				
Maternal Grandmother				
Maternal Grandfather				
Father				
Paternal Grandmother				
Paternal Grandfather				

Brother/Sister	Living/Dead/Unknown	Age	Medical Problems	Age at Diagnosis

Son/Daughter	Living/Dead/Unknown	Age	Medical Problems	Age at Diagnosis