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**

HEALTH HISTORY QUESTIONNAIRE

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

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

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

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

HEALTH HISTORY QUESTIONNAIRE

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 ◯		
Lives with	Minor children (children under the age of 18)		
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