Health History Questionnaire

Name_________________________________ Date of Birth _______________ Age_________

Phone _______________________________ Email ________________________________

Mailing Address: ____
Street or PO Box *City* *State* *Zip*

Emergency Contact: _____________________ Phone: _____________
Relationship: _______________

_ Male _ Female Physician Name & Practice Group: _____________________________

Race or Ethnic Background:
_ White, not of Hispanic origin
_ Black, not of Hispanic origin
_ American Indian/Alaskan native
_ Pacific Islander
_ Asian
_ Hispanic

Marital Status: _ Single _Married _Partnered _Widowed _Divorced/Separated

Occupation:
_Health professional
_Disabled, unable to work
_Retired
_Skilled crafts
_Technical, sales, support
_Homemaker
_Unemployed
_Student
_Operator, fabricator
_Manager, educator, professional
_Other_______

Risk Factors for Chronic Disease
Please mark with a check if your answer is yes.

_ Are you a male over the age of 45, a female over the age of 55, or a female who experienced premature menopause and is not on hormone replacement therapy?
_ Has your father or brother had a heart attack or died suddenly of heart disease before the age of 55 or has your mother or sister experienced these heart problems before age 65?
_ Do you currently use any tobacco products?
_ Has a doctor told you that you have high blood pressure, or are you on medication to control your blood pressure?
_ Has your doctor ever told you that your cholesterol is at a high-risk level?
_ Do you have diabetes mellitus?
_ Are you physically inactive or sedentary (little or no physical activity on the job or during leisure time)?
_ During the past year, would you say that you experienced enough stress, strain, and pressure to have an effect on your health?

Medications
Please list all medications, herbal supplements, and vitamins you currently take. Give the name and dosage of each.

Name	Dosage	Reason for Taking
____________________	_______	______________________________
____________________	_______	______________________________
____________________	_______	______________________________
____________________	_______	______________________________

Medical History
Please check which of the following conditions you have had in the past or now have. Also, please check conditions in your family (father, mother, brother(s), or sister(s), and children). Check all that apply.

You	Family	
_	_	Coronary heart disease, heart attack, heart surgery or repair
_	_	Angina
_	_	High blood pressure
_	_	Peripheral vascular disease
_	_	Phlebitis or embolus
_	_	Other heart problems (specify:____________________)

You Family

_ _ Cancer (location(s):____________________________________)
_ _ Stroke
_ _ Lung disease (emphysema, chronic bronchitis)
_ _ Asthma
_ _ Diabetes: Usual blood glucose values:_______
_ _ Thyroid problems
_ _ Kidney disease
_ _ Liver disease
_ _ Hepatitis
_ _ Gallstones/gall bladder disease
_ _ Osteoporosis
_ _ Arthritis
_ _ Gout
_ _ Anemia (low iron)
_ _ Diseases of the blood
_ _ Bone fractures (broken bones)
_ _ Major injury or surgery to foot, knee, hip, shoulder, elbow, or other joints
_ _ Major injury to back or neck
_ _ Stomach/ulcers
_ _ Cataracts or glaucoma
_ _ Hearing loss
_ _ Depression
_ _ Anxiety or phobias
_ _ Substance abuse problems
_ _ Eating disorders
_ _ Menstrual problems
_ _ Hysterectomy
_ _ Sleeping problems
_ _ Allergies
_ _ Other health problems (specify:_______________________________________)

Cardiovascular Disease Symptoms

Have you ever experienced...(Please mark with a check if your answer is yes.)

1. Pain or discomfort in the chest, neck, jaw, arms or upper back ________
2. Heartbeats or palpitations that feel more frequent or forceful than usual or feeling that your heart is beating very rapidly ________
3. Unusual dizziness or fainting ________
4. Shortness of breath while lying flat or a sudden difficulty in breathing which wakes you while you are sleeping ________
5. Ankle swelling unrelated to injury ________
6. Shortness of breath at rest or with mild exertion (like walking two blocks) ________
7. Feeling lame or pain in your legs brought on by walking ________
8. A known heart murmur ________
9. Unusual fatigue with usual activities ________

Other Habits

Caffeine: How many cups of regular coffee do you have daily? _____
How many caffeinated soft drinks do you have daily? _____

How many cups of caffeinated tea do you have daily? ______

Alcohol: How many servings of alcoholic beverages do you have weekly? ______

Tobacco: How many cigarettes do you smoke daily? ______
How many cigars or pipes do you smoke daily? ______
How many tobacco "chews" or "dips" do you have daily? ______
If you are an ex smoker, how many years since you quit? ______

Stress: How often would you rate your stress level as high?
Occasionally ______
Frequently ______
Constantly ______

Vision: Do you have problems with your vision? Yes No
Do you wear glasses or contact lenses? Yes No

Hearing:
Do you have difficulty hearing or understanding speech? Yes No
Do you wear a hearing aid? Yes No

Recent Health Disturbances

1. Have you had any recent illness? Please explain.

2. Have you recently been hospitalized? Please explain.

3. Have you recently had any surgical procedures? Please explain.

4. Have you recently received antibiotics or a vaccination? Please explain.

5. Do you have any chronic medical or health conditions not listed previously? Please list.