HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____/_____/_____

HEALTH HISTORY QUESTIONNAIRE

All answers to questions contained in this questionnaire are strictly confidential.

Name: *(Last, First, M.I.)*	☐ **M** ☐ **F**	**DOB** _____/_____/_____ **Marital Status:** _____
Current Doctor:	**Phone #:**	**Date of Last Physical Exam:** _____

CURRENT HEALTH HISTORY

List Any Current Medical Problems That Are Being Evaluated and/or Treated by Your Doctor:

List the Prescribed Drugs and Over-the-Counter Medicines That You Currently Take or Have Taken in the Past Month (except Supplements):

Name of Drug	Strength	Frequency Taken

Allergies to Foods, Medications, Pollens, etc:

Name the Food, Drug or Item	Reaction You Had (e.g. rash, hives, itching, runny nose, respiratory difficulty, swelling)

PAST HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

List Any Past Medical Problems That Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

LIST OF DISEASES/PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin_____
☐ Head/Neck _____
☐ Ears_____
☐ Nose _____
☐ Throat _____
☐ Lungs _____
☐ Back _____
☐ Bone disease_____
☐ Bone fracture _____
☐ Osteoporosis_____

☐ Chest/Heart _____
☐ Circulation _____
☐ Intestinal _____
☐ Bladder _____
☐ Bowel _____
☐ Arthritis_____
☐ Thyroid disease_____
☐ Diabetes _____
☐ Abnormal glucose tolerance____
☐ Abnormal blood sugar _____

☐ Elevated blood cholesterol_____
☐ Abnormal blood pressure_____

Recent Changes In:

☐ Weight_____ _____
☐ Energy Level_____ ___
☐ Appetite_____
☐ Ability to Sleep _____

Other Pain/Discomfort:

_____
_____

FAMILY HEALTH HISTORY

List all diseases which tend to occur in your blood relatives (parents, brothers, sisters, children). Especially note such illnesses as diabetes, high blood pressure, heart disease, high cholesterol levels, thyroid problems.

Parents:

Siblings:

Children:

Grandparents:

HEALTH HABITS AND PERSONAL SAFETY

Exercise and Activity Level:

Are you able to do light chores, meal preparation, or climb 10 steps without developing shortness of breath or chest pain and without assistance of others? ..... ☐ Yes ☐ No

What is your usual activity level (check one): ☐ Sedentary (No exercise)

☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)

☐ Occasional Vigorous Exercise (i.e., work or recreation, < 4 times/week for 30 min.)

☐ Regular Vigorous Exercise (i.e., work or recreation 4 or more times/week for 30 min)

Do you participate in exercise or a sports program? ..... ☐ Yes ☐ No

Please describe:_____

Describe activities during typical day_____

Diet:

Are you dieting?..... ☐ Yes ☐ No

If yes, are you on a physician prescribed medical diet? ..... ☐ Yes ☐ No

Have you lost weight? How much weight_____ over what time period_____

# of meals you eat in an average day?_____ # Snack/day_____

Caffeine:

☐ None ☐ Coffee # of Cups/day? _____ ☐ Tea # of Cups/Cans per day? _____ ☐ Cola # of Cups/Cans per day? _____

Alcohol:

Do you drink alcohol? ..... ☐ Yes ☐ No

If yes, what kind?_____ How many drinks per week? _____

Tobacco:

Do you currently use tobacco or vape? ..... ☐ Yes ☐ No

☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____

☐ Cigars - #/day _____ ☐ # of Years _____

Have you used tobacco in the past? ..... ☐ Yes ☐ No

☐ # Years used _____ ☐ # Years since you quit _____

Education and Occupation:

Please indicate highest education level. ☐ < High School ☐ High School Graduate ☐ Technical/Trade School ☐ College Graduate ☐ Postgraduate or Professional School

What is your occupation?_____

WOMEN ONLY

Age at onset of menopause:_____ Date of last menstruation: _____/_____/_____

How long is your cycle? _____ days. What is the range of your cycle length? _____

Have you had 1 cycle per month for the past 12 months? ..... ☐ Yes ☐ No

Do you consider your cycle to be regular? .... ☐ Yes ☐ No

Are you pregnant or breastfeeding? ..... ☐ Yes ☐ No

Do you plan to become pregnant in the next 12 months?..... ☐ Yes ☐ No

Do you take any birth control or estrogen medication? (please list in medication section) ..... ☐ Yes ☐ No

MEN ONLY

Do you usually get up to urinate during the night? ..... ☐ Yes ☐ No If yes, # of times _____

Do you feel pain or burning with urination? ..... ☐ Yes ☐ No

Any blood in your urine? ..... ☐ Yes ☐ No

Have you had any kidney, bladder, or prostate infections within the last 12 months? ..... ☐ Yes ☐ No

Do you have any problems emptying your bladder completely? ..... ☐ Yes ☐ No

Any testicle pain or swelling? ..... ☐ Yes ☐ No

NUTRITONAL SUPPLEMENTS

During the last two months, have you taken any vitamins, minerals, or other nutritional supplements?
☐ Yes ☐ No

If Yes, place a check for the Number of Tablets and How Long Taken:

Nutritional Supplement	Number of Tablets (place an X)					How Long Taken (place an X)		
	1 - 3 per week	4 - 6 per week	1 per day	2 per day	3 or more per day	0 – 3 months	3 -12 months	More than 1 year
Multiple Vitamins One-a-day type								
Stress-tab type								
Therapeutic, Theragram								
Other: _____								
Other Supplements								
Vitamin A								
Beta - carotene								
Vitamin C								
Vitamin E								
Vitamin B6								
Calcium or Tums								
Fish Oil								
Calcium								
Soy protein								
Whey protein								
Protein supplement								
Other, including Herbals (specify)								
Other Antioxidants (specify)								