HEALTH HISTORY QUESTIONNAIRE

Name: _____ **Today's Date:** _____

Date of Birth: _____ **Sex:** M _____ F _____

Previous or referring doctor: _____

PERSONAL HEALTH HISTORY:

Date of ***last complete physical exam***: _____
Briefly state the reason for your visit today: _____

List any *chronic* medical problems that other doctors have diagnosed:

1. _____ Year: _____
2. _____ Year: _____
3. _____ Year: _____
4. _____ Year: _____
5. _____ Year: _____

List any allergies to medications:

1. _____ Reaction you had: _____
2. _____ Reaction you had: _____
3. _____ Reaction you had: _____

List your prescribed medications and over-the-counter drugs, including vitamins and supplements:

1. _____ Strength: _____ How often: _____
2. _____ Strength: _____ How often: _____
3. _____ Strength: _____ How often: _____
4. _____ Strength: _____ How often: _____

Surgeries and any other hospitalizations:

1. Year: _____ Reason : _____ Hospital: _____
2. Year: _____ Reason: _____ Hospital: _____
3. Year: _____ Reason: _____ Hospital: _____
4. Year: _____ Reason: _____ Hospital: _____

**** Have you ever had a blood transfusion? Yes_____ No_____**

Women Only:

Date of your last menstruation? _____ Post Menopausal? Yes _____ No _____

Number of pregnancies? _____ Number of live births? _____

Are you pregnant or breastfeeding? Yes _____ No _____

Have you had a hysterectomy? Yes _____ No _____

Date of last Mammogram? _____ Date of last Pap? _____

Men Only:

Have you had any kidney, bladder, or prostate infections with the last 12 months? Yes ____ No ____

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

Do you have any difficulty with erection or ejaculation? Yes _____ No _____

Do you have any testicle pain or swelling? Yes _____ No _____

Date of last prostate or rectal exam? _____

Family Health History:

Please list any significant health problems for the following family members and their age.

Father's Age: _____ 1. _____

2. _____

Mother's Age: _____ 1. _____

2. _____

Health Habits and Personal Safety: *The following questions are optional and confidential.*

Do you drink Alcohol? Yes _____ No _____
If yes, what kind? _____ How many per/wk? _____
Do you use tobacco? Yes _____ No _____
If yes, what kind? _____ How often? _____
Do you currently use recreational or street drugs? Yes _____ No _____
If yes, what kind? _____
Have you ever given yourself street drugs with a needle? Yes _____ No _____