HEALTH HISTORY QUESTIONNAIRE

Name:		DOB:
Height:	Weight:	
Hospital Used:		
Reason for Visit Today:		
ALLERGIES: List all known allergies	☐ **No Known Drug Allergies**	
List all Prescribed and Over the Counter (OTC) medications, including Vitamins or Herbal		
MEDICATIONS:		

Social History

Marital Status: ______________________________ Occupation: __________________________________

Smoking Status: ☐ Never ☐ Former When did you quit? ________________________

☐ Current every day ☐ Current some days ☐ Cigars

Smoking – how much? ☐ None ☐ 1 PPW ☐ 2 PPW ☐ ¼ PPD ☐ ½ PPD ☐ 1 PPD ☐ 1 ½ PPD ☐ 2 PPD

Military History: ☐ Yes ☐ No

Do you drink alcohol? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Caffeine Intake? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Illicit Drugs? ☐ Yes ☐ No

Are you in pain? (¿Tiene Dolor?)

Please circle one:

0	1 - 2	3 - 4	5 - 6	7 - 8	9 - 10
very happy, no pain (Muy feliz Sin dolor)	hurts just a little bit (Duele un poquito)	hurts a little more (Duele un poco más)	hurts even more (Duele aún más)	hurts a whole lot (Duele mucho)	hurts as much as possible (Duele tanto como pueda imaginar)

Name:

Past Medical History

Condition			Condition		
Anxiety Disorder	☐ yes	☐ no	High Blood Pressure	☐ yes	☐ no
Arthritis	☐ yes	☐ no	High Cholesterol	☐ yes	☐ no
Aspirin/Blood Thinner Use	☐ yes	☐ no	HIV	☐ yes	☐ no
Asthma	☐ yes	☐ no	Hot Flashes	☐ yes	☐ no
Bed Wetting	☐ yes	☐ no	Hypertension	☐ yes	☐ no
Benign Prostatic Hyperplasia (BPH)	☐ yes	☐ no	Hyperthyroidism	☐ yes	☐ no
Bipolar	☐ yes	☐ no	Incontinence	☐ yes	☐ no
Bladder Cancer	☐ yes	☐ no	Infertility	☐ yes	☐ no
Bladder Infections	☐ yes	☐ no	Kidney Disease	☐ yes	☐ no
Blood Clots	☐ yes	☐ no	Kidney Infections	☐ yes	☐ no
Blood in Urine	☐ yes	☐ no	Kidney Stones	☐ yes	☐ no
Bone Pain	☐ yes	☐ no	Liver Disease	☐ yes	☐ no
Cancer	☐ yes	☐ no	Nocturia	☐ yes	☐ no
Cardiac Stents	☐ yes	☐ no	Osteoporosis	☐ yes	☐ no
COPD	☐ yes	☐ no	Pacemaker	☐ yes	☐ no
Coronary Artery Disease	☐ yes	☐ no	Pelvic Prolapse	☐ yes	☐ no
Cystitis	☐ yes	☐ no	Prostate Cancer	☐ yes	☐ no
Decreased Libido	☐ yes	☐ no	Prostate Problems	☐ yes	☐ no
Defibrillator	☐ yes	☐ no	Prostatitis	☐ yes	☐ no
Depression	☐ yes	☐ no	Pulmonary Embolism	☐ yes	☐ no
Diabetes	☐ yes	☐ no	Renal Cyst	☐ yes	☐ no
Diverticulitis	☐ yes	☐ no	Schizophrenia	☐ yes	☐ no
Dysuria	☐ yes	☐ no	Sleep Apnea	☐ yes	☐ no
Elevated PSA	☐ yes	☐ no	Slow Flow	☐ yes	☐ no
Erectile Dysfunction	☐ yes	☐ no	Stroke	☐ yes	☐ no
Glaucoma	☐ yes	☐ no	Urge Incontinence	☐ yes	☐ no
Heart Attack	☐ yes	☐ no	Urgency	☐ yes	☐ no
Heart Disease	☐ yes	☐ no	Urinary Catheterization	☐ yes	☐ no
Hepatitis C	☐ yes	☐ no	Urinary Frequency	☐ yes	☐ no
Herpes	☐ yes	☐ no	Urinary Tract Infection	☐ yes	☐ no

Additional:

Are you feeling depressed? ☐ **NO** ☐ **YES**

If YES, depression due to: ☐ **Life** ☐ **Environmental** ☐ **Disease** ☐ **Post-Partum** ☐ **Cancer** ____

Name:

Surgical History	Year

Family History	Relationship (maternal/paternal)

REVIEW OF SYSTEMS

What are the symptoms you are experiencing? Circle Any/All Symptoms That Apply Today

Constitutional	Fever	Chills	Weight Loss	Fatigue	
Eyes	Changes in Vision	Blurred Vision			
Head, Ears, Nose Throat (HENT)	Sore Throat	Nasal Congestion	Nasal Discharge	Sinus Pain	Headaches
Breasts	Lumps	Tenderness	Nipple Discharge		
Cardiovascular	Chest Pain	Cardiac Murmurs	Irregular Heart Beats	Dyspnea on exertion	
Respiratory	Shortness of Breath	Wheezing	Cough		
Gastrointestinal	Nausea	Vomiting	Change in Abnominal Girth	Diarrhea	Constipation
	Blood in Stool				
Genuitourinary	Urgency	Frequency	Dysuria	Nocturia	
Integument	Rash	Itching	New Skin Lesions		
Neurologic	Tingling or numbness	Incoordination	Seizures		
Musculoskeletal	Bone Pain	Back Pain	Joint Pain	Other Pain	
Endocrine	Polyuria	Polydipsia	Cold Intolerance	Heat Intolerance	Weight Gain
	Weight Loss				
Psychiatric	Anxiety	Depression	Bipolar Disorder		
Heme-Lymph	Easy Bleeding	Easy Bruising	Lynph Node Enlargement or Tenderness		
Allergic-Immnologic	Sinus Allergy Symptoms	Frequent Colds			

Other Symptoms:

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X____ ___________________________

Patient or Guardian Signature Date