

Health History Questionnaire

Name: _____ Sex: Male Female

Today's date: _____ Age: _____

Reason for visit: _____

General health

Lung Trouble?
 Asthma? Yes No
 Shortness of Breath? Yes No
 Other? Yes No

Heart Trouble?
 Heart Attack? Yes No
 Irregular Pulse? Yes No
 Chest Pain? Yes No

High Blood Pressure? Yes No

Gastrointestinal Trouble?
 Ulcers or bleeding? Yes No
 Irritable Bowels? Yes No
 Colitis or Crohn's? Yes No

Colon Trouble?
 Colon cancer? Yes No
 Colon polyps? Yes No
 Family history of colon cancer? Yes No
 FHx colon polyps? Yes No
 Bloody stools? Yes No
 Change in bowel habits? Yes No
 Personal history colon polyps? Yes No
 Prior colonoscopy? Yes No

Liver Trouble?
 Jaundice? Yes No
 Hepatitis? Yes No

Kidney Trouble? Yes No

Diabetes? Yes No

Arthritis? Yes No

Neurologic Trouble?
 Migraines? Yes No
 Seizures? Yes No
 Stroke? Yes No

Surgery History

Have you ever had surgery? Yes No
 If yes, what kind? _____

Medications

Do you take blood thinners? Yes No

Do you take steroids? Yes No

Do you take other medicines? Yes No
 If Yes, please list with the dosages.

Allergies to Medicines? Yes No

If Yes, to which ones? _____

Do you smoke? Yes No

Do you drink alcohol? Yes No

If Yes, how much? _____

Breast Health (complete for breast exams only)

How was the current problem discovered?

Mammogram Yes No

Self Exam Yes No

Doctors Exam Yes No

Previous Breast Surgery? Yes No

If Yes, what type? _____

Family History of Breast Cancer? Yes No

If Yes, who? _____

Have You Given Birth? Yes No

If Yes, how old are your children. _____

Menopause? Yes No

If Yes, when? _____

Have you taken Estrogen? Yes No

If Yes, for how long? _____

