

PATIENT HISTORY QUESTIONNAIRE

Name _____ Age ____ Birth date _____ Today's Date _____

Address _____

Hm. Phone _____ Wk. Phone _____ Who referred you to this office _____

List other Doctors treating you _____

MAIN COMPLAINT: _____ DATE OF ONSET _____

DO YOU HAVE A HISTORY OF:

Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Lung Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Gout	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Stomach/Ulcer Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heart Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Arterial Insufficiency	<input type="checkbox"/> No	<input type="checkbox"/> Yes
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood Transfusion	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Venous Stasis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Colon Polyps	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Chemical Dependence	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Colon Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bleeding Tendency	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Paralysis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Breast Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Colitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Previous Anesthesia Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes

List all past operations and serious illnesses:

Operation or illness	Month and Year	City, State

Recent x-rays, labs or tests	Date	Facility/Doctor

Please list all medications that you are currently taking:

Medicine	Dose	Frequency	For What Illness?

Are you allergic to any medicines? What type of reaction do you have? Yes No

If so, list:

Do you smoke? Yes No How Much?

Do you drink alcohol? Yes No How Much?

Previous Steroid use? Yes No How Much?

FAMILY HISTORY: Age State of Health Age at Death Cause of Death

Father: _____

Mother: _____

Brother/Sister _____

(State Which) _____

HAS ANY BLOOD RELATIVE EVER HAD:

Tuberculosis	<input type="checkbox"/> No	Yes, Relative _____	Lung Disease	<input type="checkbox"/> No	Yes, Relative _____
Diabetes	<input type="checkbox"/> No	Yes, Relative _____	Stroke	<input type="checkbox"/> No	Yes, Relative _____
Heart Disease	<input type="checkbox"/> No	Yes, Relative _____	Arthritis	<input type="checkbox"/> No	Yes, Relative _____
High Blood Pressure	<input type="checkbox"/> No	Yes, Relative _____	Arteriosclerosis	<input type="checkbox"/> No	Yes, Relative _____
Bleeding Tendency	<input type="checkbox"/> No	Yes, Relative _____	Kidney Disease	<input type="checkbox"/> No	Yes, Relative _____
Colon Cancer	<input type="checkbox"/> No	Yes, Relative _____	Unusual Anesthetic Reaction	<input type="checkbox"/> No	Yes, Relative _____
Colitis	<input type="checkbox"/> No	Yes, Relative _____	Congenital Deformities	<input type="checkbox"/> No	Yes, Relative _____
Breast Cancer	<input type="checkbox"/> No	Yes, Relative _____		<input type="checkbox"/> No	Yes, Relative _____