

HEALTH HISTORY QUESTIONNAIRE

Name:		DOB:
Height:	Weight:	
Hospital Used:		
Reason for Visit:		
ALLERGIES: List all known allergies <input type="checkbox"/> 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?)



0
very happy,
no pain
(Muy feliz
Sin dolor)



1 - 2
hurts just
a little bit
(Duele un
poquito)



3 - 4
hurts a
little more
(Duele un
poco más)



5 - 6
hurts even
more
(Duele
aún más)



7 - 8
hurts a
whole lot
(Duele
mucho)



9 - 10
hurts as much
as possible
(Duele tanto como
pueda imaginar)

Past Medical History

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

Additional:

Are you feeling depressed?

NO YES

If YES, depression due to:

Life Environmental Disease Post-Partum
 Cancer _____

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			
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	Lymph Node Enlargement or Tenderness		
Allergic-Immologic	Sinus Allergy Symptoms	Frequent Colds			

Other Symptoms:

X

Patient or Guardian Signature

Date