Family Practice of Suntree and Viera, P.A.

Health History Questionnaire

NAME: _____ **D.O.B.** _____ **DATE:** _____

Medical History:

Please list all **P** for Past and **C** for current medical problems.

___ Anemia
___ Anxiety
___ Asthma
___ Blood transfusion
___ Enlarged Prostate
___ Borderline diabetic
___ Coronary Artery disease
___ Cataracts
___ Congestive heart failure
___ Neuropathy
___ Atrial Fib/Arrhythmia
___ Cancer: type _____

___ COPD
___ CVA/Stroke
___ Depression
___ Emphysema
___ Gallstones
___ Glaucoma
___ Gout
___ Heart disease
___ Heart attack
___ Shortness of breath
___ Blood clot/DVT

___ Liver Disorders (Hepatitis)
___ Hypothyroid
___ HIV
___ High cholesterol
___ High blood pressure
___ Kidney stones
___ Leukemia
___ Migraine headaches
___ Diabetes:non-insulin dependent
___ Diabetes: insulin dependent
___ Reflux/GERD
___ Diverticulosis

___ Arthritis
___ Osteoporosis
___ Stomach ulcers
___ Pneumonia
___ Kidney failure
___ Seizure disorder
___ Memory loss
___ Thyroid disorder
___ Low testosterone
___ Tobacco abuse
___ Back pain
___ Dizziness

Allergies: _____

Previous Surgeries:	**Year**	**Hospitalizations/Reason:**	**Year**
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Family History:

Father: Living / Deceased Age: _____ History: _____

Mother: Living / Deceased Age: _____ History: _____

Any one in your family with a history of high blood pressure, diabetes, heart disease, stroke, seizures or Cancer? (example:sister/high blood pressure, mother/stroke, maternal grandma/cancer) _____

_____

_____

Social History:

Alcohol:

Do you drink alcohol? Yes or No

Drinks per day:
Beer _____ Wine _____ Hard Liquor _____

Occupation: _____

Smoking or Tobacco Use:

Have you ever smoked? Yes or No
Are you still smoking? Yes or No
Packs per day _____
How many years? _____
Quit in what year? _____

Year of last tetanus shot? _____ Last Flu shot? _____ Last pneumonia shot? _____

Review of systems: Please check off any recent or new problems that apply to your health

General Health:
___ Fatigue
___ Poor appetite
___ Fevers or chills
___ night sweats

Head & Neck
___ Headaches
___ Dizziness
___ Lightheaded
___ Trauma
___ Blacking out

Ear, Nose & Throat
___ eye pain
___ blurred/double vision
___ sore throat
___ sinus/throat pain
___ hearing loss
___ ringing in ears
___ excess ear wax

Skin
___ rash
___ lesions/sores
___ easy bruising
___ dry skin

Endocrine/Hormones
___ hot flashes
___ hair loss
___ sexual dysfunction
___ heat/cold intolerance

Cardiac/Heart
___ chest pain
___ shortness of breath
___ palpitations
___ fatigue w/exercise
___ general swelling

Pulmonary/Lungs
___ shortness of breath
___ cough
___ wheezing
___ bloody sputum

Digestive/Abdomen
___ heartburn
___ nausea/vomiting
___ diarrhea
___ constipation
___ bloody stools
___ black tarry stools
___ abdominal pain

Urinary/Genital
___ painful urination
___ blood in urine
___ discharge or lesion
___ urinary frequency
___ incontinence
___ STD exposure

Joints/Muscle
___ back pain
___ joint pain
___ muscle pain
___ swelling/edema
___ muscle spasms
___ numbness/tingling

Neurological
___ neuropathy
___ loss of consciousness
___ seizures
___ muscle weakness
___ dizziness
___ focal deficits
___ loss of balance
___ slurred speech

Medications: Please list all medications, vitamins and supplements that you are currently taking.

Name:	**Dose (mg)**	**Reason for taking**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Women only:
Last Menstrual Period: _____ Might you be pregnant? Yes____ No____ Unsure____
Contraceptive Method: None___ Pills ___ Condoms ___ Surgical ___ Menopause ___ Other ___
Number of times pregnant: _____ # of Deliveries: _____ # of Children _____
Last Pap Smear: _____ Performed by Dr: _____ Results: _____
Prior abnormal Pap? Yes / No When? _____
Action taken for abnormal pap? Repeat exam _____ Cryotherapy _____ Cone _____ LEEP _____ Other
Last Mammo:_____ Results: _____ Last bone density: _____ Results: _____