WESLEYCHAPEL
INTERNAL MEDICINE AND PEDIATRICS
Manish Shah MD, FAAP

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Occupation:	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

Review of systems: If you answer yes to any of the questions below, please explain.

GENERAL

1. Unexplained weight loss ☐ Yes ☐ No What was the magnitude of this weight loss? 0-5 lbs.☐ 5-15 lbs.☐ 15-25 lbs. ☐ >25 lbs. ☐

2. Unexplained weight gain	☐ Yes ☐ No	5. Night Sweats	☐ Yes ☐ No
3. Chronic Fatigue	☐ Yes ☐ No	6. Fever or chills	☐ Yes ☐ No
4. Change in appetite	☐ Yes ☐ No	7. Any type of cancer	☐ Yes ☐ No

HEART/VASCULAR

8. Chest pain or pressure	☐ Yes ☐ No	15. Calf pain with exercise	☐ Yes ☐ No
9. Chest pain with exertion	☐ Yes ☐ No	16. Varicose veins	☐ Yes ☐ No
10. Heart Attack	☐ Yes ☐ No	17. Phlebitis	☐ Yes ☐ No
11. Rapid/Irregular heartbeats	☐ Yes ☐ No	18. Stroke	☐ Yes ☐ No
12. Fainting/Lightheadedness	☐ Yes ☐ No	19. High blood cholesterol	☐ Yes ☐ No
13. High blood pressure	☐ Yes ☐ No	20. High blood triglycerides	☐ Yes ☐ No
14. Rheumatic fever	☐ Yes ☐ No		

EYES

21. Decrease in vision	☐ Yes ☐ No	24. Color blindness	☐ Yes ☐ No
22. Double vision	☐ Yes ☐ No	25. Cataracts	☐ Yes ☐ No
23. Glaucoma	☐ Yes ☐ No	26. Serious injury to eye	☐ Yes ☐ No

EAR-NOSE-THROAT

27. Hearing loss	☐ Yes ☐ No	31. Ruptured eardrum	☐ Yes ☐ No
28. Prolonged exposure to loud noise	☐ Yes ☐ No	32. Snoring	☐ Yes ☐ No
29. Ringing in ears	☐ Yes ☐ No	33. Sinus infection	☐ Yes ☐ No
30. Chronic ear infections	☐ Yes ☐ No	34. Allergy related nasal congestion	☐ Yes ☐ No

BONE & JOINT

35. Chronic joint & muscle pain	☐ Yes ☐ No	38. Arthritis	☐ Yes ☐ No
36. Low back pain	☐ Yes ☐ No	39. Gout	☐ Yes ☐ No
37. Swollen/stiff joints	☐ Yes ☐ No		

ENDOCRINE

40. Thyroid disease ☐ Yes ☐ No 41. High blood sugar ☐ Yes ☐ No 42. Diabetes ☐ Yes ☐ No

PULMONARY

43. Chronic cough or phlegm	☐ Yes ☐ No	48. Pneumonia	☐ Yes ☐ No
44. Wheezing	☐ Yes ☐ No	49. Emphysema	☐ Yes ☐ No
45. Asthma	☐ Yes ☐ No	50. Coughed up blood	☐ Yes ☐ No
46. Tuberculosis	☐ Yes ☐ No	51. Shortness of Breath	☐ Yes ☐ No
47. Bronchitis	☐ Yes ☐ No		

GASTROINTESTINAL

52. Ulcer disease	☐ Yes ☐ No	59. Diarrhea caused by milk/lactose intolerance	☐ Yes ☐ No
53. Frequent heartburn	☐ Yes ☐ No	60. Blood in stools	☐ Yes ☐ No
54. Vomited blood	☐ Yes ☐ No	61. Black stool	☐ Yes ☐ No
55. Gallbladder trouble	☐ Yes ☐ No	62. Hemorrhoids	☐ Yes ☐ No
56. Abdominal Pain	☐ Yes ☐ No	63. Colon Polyps	☐ Yes ☐ No
57. Jaundice, hepatitis, or cirrhosis	☐ Yes ☐ No	64. Chronic constipation	☐ Yes ☐ No
58. Frequent diarrhea	☐ Yes ☐ No		

NEUROPSYCHIATRY

65. Loss of consciousness	☐ Yes ☐ No	71. Difficulty sleeping	☐ Yes ☐ No
66. Vertigo	☐ Yes ☐ No	72. Depression	☐ Yes ☐ No
67. Memory problems	☐ Yes ☐ No	73. Anxiety	☐ Yes ☐ No
68. Seizures or epilepsy	☐ Yes ☐ No	74. Nervous breakdown	☐ Yes ☐ No
69. Frequent headaches	☐ Yes ☐ No	75. Psychiatric or psycho-logical counseling	☐ Yes ☐ No
70. Numbness or tingling of arms, legs, or face	☐ Yes ☐ No		

HEMATOLOGY

77. Anemia	☐ Yes ☐ No	79. Previous blood transfusion	☐ Yes ☐ No
78. Bleeding disorder	☐ Yes ☐ No	80. Enlarged or swollen lymph nodes	☐ Yes ☐ No

DERMATOLOGY

81. Skin Rash	☐ Yes ☐ No	86. Mouth sores that won't heal	☐ Yes ☐ No
82. Skin cancer	☐ Yes ☐ No	87. Psoriasis	☐ Yes ☐ No
83. Shingles/herpes zoster	☐ Yes ☐ No		
84. Skin sores that won't heal	☐ Yes ☐ No		

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

NUTRITIONAL SUPPLEMENT INFORMATION

Are you presently taking any type of nutritional supplements (vitamins, minerals, herbs, amino acids, fish oils, etc)?	☐ Yes	☐ No
Name the supplements that you are presently taking:		
Who recommended you take these supplements?		
Where did you purchase these supplements?		
If this practice offered an advanced, high quality line of supplements, would you consider purchasing them?	☐ Yes	☐ No
If this practice offered a simple genetic test to determine what supplemental regimen is best for you, based on your genetic variations,		
Would you consider doing it?	☐ Yes	☐ No
If this Practice offered a comprehensive weight management program, would you consider it?	☐ Yes	☐ No
If this practice offered a nutrition education program to improve your dietary habits, would you consider it?	☐ Yes	☐ No
By appointment with one of our staff?	☐ Yes	☐ No
By a class exclusively for our patients?	☐ Yes	☐ No