



_	nal Date:
	s Revised:

HEALTH HISTORY QUESTIONNAIRE

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

	I.I.):					□F	DOB:				
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	□w	idowed				
Previous or referring doctor:						Date of last physical exam:					
			DED	SONAL HEAL	TH HISTORY						
Childhood illnes	ss: □ M	leasles Mump	s 🗆 Rubella	☐ Chickenpox	☐ Rheumati	c Fever	□ Polio .				
Immunizations	and	☐ Tetanus			☐ Pneui	monia					
dates:	labor series	☐ Hepatitis	A CONTRACTOR OF THE PROPERTY O	AND STREET, STREET, AT THE STREET, STR	☐ Chick	enpox					
		☐ Influenza	Quantities		iumps, Rubella						
List any medica	l problem	s that other doc	tors have dia	gnosed							
21/42											
Surgeries	en andre de la companya de la compa	And the state of t	A CONTRACTOR OF THE PROPERTY O		Annual State of the Control of the C						
	ason						Hospital				
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The state of the s		A PARAMETER STATE OF THE STATE	ATTI ASSESSMENT OF THE PARTY OF								
Other hospitali	zations										
	eason						Hospital				
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Original	Date:
Dates Re	evised:

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Hame (1994)	irst, M.I.):					□м	□F	DOB:				
Marital stat	us: 🗌 Sin	gle 🗌 Pa	artnered	☐ Married	☐ Separated	☐ Divorced	_ □ Wie	lowed				
Previous or	referring d	octor:				Date of I	ast phys	ical exam:	Market Market - In the American			
	7734 Julius						42 of 5.					
				PER	RSONAL HEAL	TH HISTORY			1828-18-60			
Childhood il	ilness: [] Measles	☐ Mump	s 🗆 Rubella	☐ Chickenpox	□ Rheumatio	Fever	□ Polio	ALL			
Immunizati		☐ Tetar	nus	a and a second construction of the second constr	enne en a populario de la companya d	☐ Pneum	nonia					
dates:		□ Нера	titis			☐ Chicke	npox	00X				
		☐ Influe				☐ MMR /	Measles, Mu	nps, Rubella	and a second respective to the second			
List any me	dical probl	ems that o	ther doc	ors have dia	gnosed							
	and the same of the	C. 1. ((A61., 1)					ta i i		_			
Surgeries	T.						14	Hospital				
Surgeries Year	Reason						III	Hospital				
	Reason							Hospital				
	Reason							Hospital				
	Reason	V 2 (AR)						Hospital				
	Reason							Hospital				
Year								Hospital				
Year Other hosp	italizations							Hospital				
Year												
Year Other hosp	italizations											
Year Other hosp	italizations											
Year Other hosp	italizations											
Year Other hosp	italizations											
Year Other hosp	italizations											

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List your pres	scribed drugs and over-	-the-counter drugs, su	ch as vitamins and inha	lers						
Name the Drug]	Strength		Frequency Taken						

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AND THE PARTY AND AND THE PARTY OF THE PARTY										
e commence de la commencia de commencia de la										
Allergies to n	nedications									
Name the Drug		Reaction You H	ad							
		A CONTRACTOR OF THE PROPERTY O								
					Karangan dan dan saka					
		HEALTH HAB	ITS AND PERSONAL!	SAFETY						
ger i han nyayayaragan akka ini shan a kaan kaganaayan sakaladan kansa sakan sakan kadan ka			t Tweeters	NATION WENT CENTON V	ONIFTOPNITTA			MAN THE PROPERTY OF THE PARTY O		
a			IAIRE ARE OPTIONAL AND	WILL BE KEPT STRICTLY C	ONFIDENTIA	L.				
Exercise	☐ Sedentary (No exe	PART RESERVE TO THE RESERVE TO								
		climb stairs, walk 3 block		-l- 6 20i- \	1. 1		Manager discoloring and adjuste	and the second second second second second second		
		☐ 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)								
		xercise (i.e., work or recr	eation 4x/week for 30 min	lutes)				No		
Diet	Are you dieting?		_1_1_1			Yes				
		hysician prescribed medic	al diet?			165	<u> </u>	No		
	# of meals you eat in				i di esti di e					
	Rank salt intake	O HI	☐ Med	Low						
	Rank fat intake	☐ Hi	☐ Med	Low				##		
Caffeine	□ None	Coffee	Tea	Cola						
	# of cups/cans per da	ıy?								
Alcohol	Do you drink alcohol?					Yes		No		
	If yes, what kind?	CONTRACTOR OF THE PROPERTY OF						Automorphis - 62		
	How many drinks per									
		out the amount you drink	?			Yes Yes		No		
	Have you considered stopping?							No		
	Have you ever experienced blackouts?							No		
	Are you prone to "binge" drinking?							No		
	Do you drive after dri	Do you drive after drinking?						No		
Tobacco	Do you use tobacco?					Yes		No		
1	☐ Cigarettes – pks./c	day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigar	☐ Cigars - #/day				
	# of years	☐ Or year quit								
Drugs	Do you currently use	recreational or street dru	gs?	nymanajunka se e ayar e ama ayyar ka kanyanyan anak seka sekanyan anak a a a		Yes		No		
	Have you ever given	yourself street drugs with	a needle?			Yes		No		

Sex	Are you sexua	Are you sexually active?							No	
	If yes, are you trying for a pregnancy?								No	
	If not trying for a pregnancy list contraceptive or barrier method used:									
	Any discomfo	Any discomfort with intercourse?								
	problem. Risk	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?								
Personal	Do you live a	Do you live alone?								
Safety	Do you have frequent falls?								No	
	Do you have	vision or hearing loss?					Yes		No	
	Do you have	an Advance Directive and/or Living Will?					Yes		No	
	Would you lik	e information on the preparation of these	?				Yes		No	
	Physical and/ the form of vissue with you	or mental abuse have also become major erbally threatening behavior or actual phy ur provider?	public health issue sical or sexual abu	es in this country se. Would you lil	. This often takes ke to discuss this		Yes		No	
		FAMILY HEA	ALTH HISTORY		phin in the second seco					
And the second s	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT I	HEAL	TH PR	OBLE	MS	
Father			Children	□ M □ F					######################################	
Mother				☐ M ☐ F						
Sibling	□ M □ F			O M						
	□ M □ F			□ M □ F						
	□ M □ F		Grandmother Maternal							
	□ M		Grandfather							
	□ F □ M □ F		Grandmother Paternal			and the second s				
	□ M □ F		Grandfather Paternal							
		MENTA	L HEALTH &	enia de la composición dela composición de la composición de la composición de la composición dela composición dela composición dela composición de la composición de la composición dela composición de la composición dela composición del		5	i sec			
Is stress a m	ajor problem for y	ou?				L	Yes		No	
Do you feel o	lepressed?] Yes		No	
Do you panio	when stressed?) Yes		No	
Do you have	problems with eat	ing or your appetite?] Yes		No	
Do you cry fr	equently?			······································		Ę] Yes		No	
Have you eve	er attempted suicio	le?] Yes		No	
Have you ev	er seriously though	nt about hurting yourself?] Yes		No	
Do you have	trouble sleeping?] Yes		No	
Have you ev	er been to a couns	elor?] Yes		No	

WOMEN ONLY

Age at onset of menstruation:							
Date of last menstruation:							
Period every days			and the second of the second o		A STATE OF THE PARTY OF THE PAR	engan-ny-ka-ny-kaosan-sa kao	Anna Anna Anna Anna Anna Anna Anna Anna
Heavy periods, irregularity, spotting, pain, or disc	harge?				Yes		No
Number of pregnancies Number of live bit	ths		***************************************				***************************************
Are you pregnant or breastfeeding?					Yes		No
Have you had a D&C, hysterectomy, or Cesarean	?		archiverance (1971). Berlin and archiverance (1971) archiverance (1971		Yes		No
Any urinary tract, bladder, or kidney infections wi	thin 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, in	itability, or other symptoms at or around time of pe	eriod			Yes		No
Experienced any recent breast tenderness, lumps	, or nipple discharge?				Yes		No
Date of last pap and rectal exam?					:		. :

在1000年中的1000年代 1000年代	MEN ONLY						D V
Do you usually get up to usingte during the night				7—			
Do you usually get up to urinate during the night					Yes		No
If yes, # of times				T_		I —	
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 inf					Yes		No
Do you have any problems emptying your bladde	r completely?				Yes		No
Any difficulty with erection or ejaculation?				빝	Yes		No
Any testicle pain or swelling?					Yes		No
Date of last prostate and rectal exam?							
	OTHER PROBLEMS			YS-134	\$4.5E	1.12.14	
	OHER POSICIO						
Check if you have, or have had, any symptoms in	the following areas to a significant degree and brie	fly ex	«plain.				Address
		r: ::					
Skin	☐ Chest/Heart		Recent changes in:				
☐ Head/Neck	☐ Back		Weight				
☐ Ears	☐ Intestinal		Energy level				
Nose	☐ Bladder		Ability to sleep				
☐ Throat	☐ Bowel		Other pain/discomfort	:			
Lungs	☐ Circulation						